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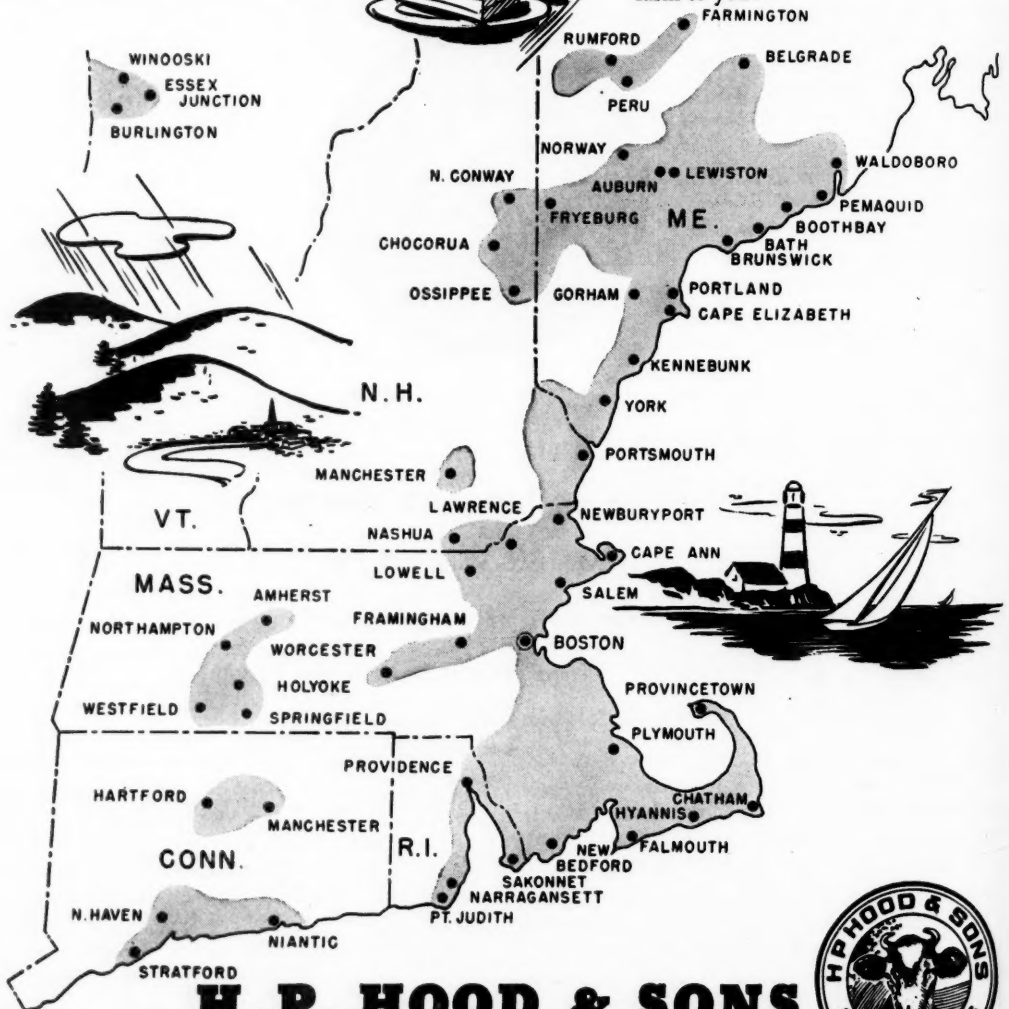
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The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island
Copyright 1948, The Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island
Single copies, 25 cents . . . Subscription, \$2.00 per year.

Vol. XXXI, No. 7

July, 1948

TABLE OF CONTENTS

	PAGE
Neurological Aspects of Poliomyelitis, <i>Henry R. Viets, M.D.</i>	427
The Challenge of Medicine in the Atomic Era, <i>Edward L. Bortz, M.D.</i>	430
A New Technique in the Radical Cure of Hydrocele, <i>Vincent J. Oddo, M.D.</i>	433
Fundamentals of Staff Organization, <i>Charles F. Wilkinson, Jr., M.D.</i>	437

EDITORIALS

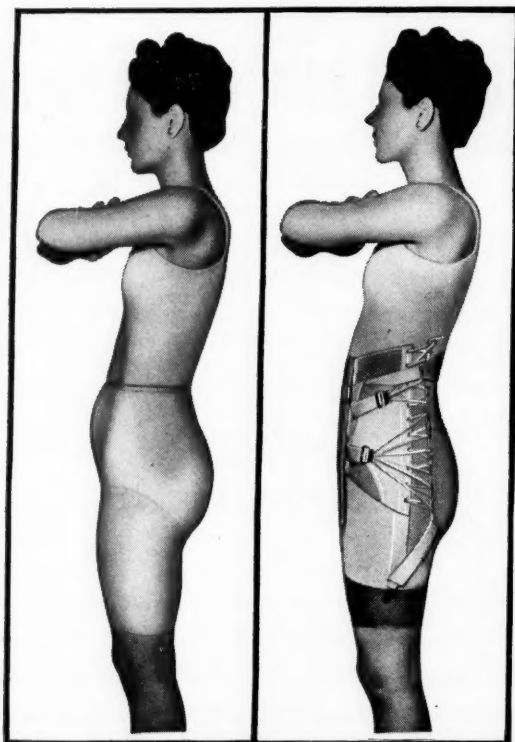
Treatment of Bulbar Poliomyelitis	439
Guy W. Wells, M.D.	440

DEPARTMENTS

Annual Dinner, R. I. Medical Society.....	444
Annual Reports, R. I. Medical Society.....	456
District Medical Society Meetings.....	452
General Session, R. I. Medical Society.....	442

MISCELLANEOUS

Additional Participating Physicians, R. I. Surgical Plan	448
Index of Advertisers	467
<i>Photograph: Joseph C. O'Connell, M.D., Inducted as President</i>	443



Patient of intermediate type of build; roentgenograms showed spondylolisthesis, grade 1, with congenital defects. Symptoms developed after a fall on the ice during pregnancy.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI

JULY, 1948

NO. 7

NEUROLOGICAL ASPECTS OF POLIOMYELITIS*

HENRY R. VIETS, M.D.

The Author. Henry R. Viets, M.D., of Boston. Lecturer on Neurology, Harvard Medical School; Neurologist, Massachusetts General Hospital.

POLIOMYELITIS continues to be an ever present menace to the health of the citizens in the United States and indeed throughout the world. Great epidemics of this disease have swept this country in the last few years. In 1916 occurred the greatest epidemic of recent times but there was a marked upswing in the number of cases in 1943, 1944, 1945 and 1946. Indeed the epidemic of 1946 proved to be, with the exception of 1916, the largest this country had ever experienced with over 25,000 recorded cases.

In recent years there has been a high rate of bulbar poliomyelitis in many areas of the country. In the 1946 Minnesota epidemic, for instance, the incidence of bulbar involvement among the unselected cases of the disease in patients admitted to an emergency clinic was 23 percent in children under sixteen years of age and even higher in patients beyond this age.¹ Furthermore, of 1300 cases observed in 1943 to 1946, from Rockford and Cook County, Illinois, and Hickory, North Carolina, over a fifth were of the bulbar or bulbar-spinal type and the fatality rate in this group was 23.2 percent for the bulbar cases and 46 percent for the bulbar-spinal cases. In contrast, the spinal cases, about four-fifths of the total number, had a fatality rate of slightly over 1 percent.² The number of bulbar cases, therefore, formed a greater proportion of the whole than had previously been reported in poliomyelitis statistics and the fatality rate was almost uniformly high in each year from 1943 on. Newer forms of treatment, many of them inaugurated as recently as 1946, have resulted in a marked improvement in this rate, an important aspect of poliomyelitis that should be given consideration at this time.

* Presented before the Rhode Island Medical Society at its 137th Annual Meeting, at Providence, May 13, 1948.

It should not be forgotten, however, that there are other large problems connected with poliomyelitis that deserve our full consideration: studies on epidemiology, other virus diseases, chemotherapy, transmission by direct contact, by excreta, by animals such as the fly, rodents and others, and finally the bio-chemical reactions of the nervous system that might be of use in creating a barrier against the invasion of the virus or its neutralization before it penetrates deeply into the vital tissues such as the anterior horn cells. Each of these aspects of the problem is being actively investigated at various clinics and research centers in this country. The National Foundation for Infantile Paralysis gives financial assistance to many of these centers and acts as a stimulating agent for research throughout the country.³ This great effort, combined with other stimuli of a similar nature, gradually is encompassing the problem of the cause and transmission of poliomyelitis. Until the cause of poliomyelitis is found and means for its elimination made available, the principal activity against the disease from the physician's viewpoint must be in the therapeutic field and the emergency care of the patient with bulbar poliomyelitis becomes a matter of primary importance.

Bulbar Poliomyelitis

Bulbar poliomyelitis is now considered as a disease primarily affecting the whole of the brain stem, including the medulla, pons and midbrain. Four symptom complexes are now recognized for the purposes of classification and for more adequate treatment of the emergency case. Each of the clinical groups presents special problems, both in diagnosis and in treatment and it is necessary to visualize them in order to handle a case of bulbar poliomyelitis efficiently. Primarily diagnosis is in the hands of a general practitioner who usually is the first to see a patient with signs of poliomyelitis. The patient with the spinal form of the disease, with paralysis of the arms and legs, usually presents no problem in diagnosis once the

continued on next page

paralysis has disclosed itself. The clue to bulbar poliomyelitis is found in (1) the involvement of the nuclei of the cranial nerves with resulting paralysis of the muscles supplied by them, (2) in a disturbance of the respiratory or circulatory centers in the brain stem, or finally, (3) in the mental symptoms due to encephalitis, an unusual manifestation of this disease.

(1) *Cranial nerve paralysis.* Any of the motor nuclei of the cranial nerves may be affected in poliomyelitis. These consist of the third, fourth and sixth cranial nerves supplying the muscles which move the eye; the motor component of the fifth cranial nerve supplying the masseter and pterygoid muscles; the seventh cranial nerve supplying the muscles of expression of the face; the ninth supplying the pharynx; the tenth which supplies both the pharynx and the larynx; the eleventh supplying the trapezius and sterno-mastoid muscles in the shoulders and neck; and the twelfth supplying the tongue. All except the tenth give rise to the symptom of relatively minor significance. None cause death in the acute stage of poliomyelitis, although pharyngeal paralysis may be a contributing cause. It is only when the tenth cranial nerve is involved, with resulting dysphagia and dysarthria that life is primarily endangered. Thus the importance of the paralysis of muscles supplied by cranial nerves other than the tenth lies in their value as indicators of disease in the brain stem rather than as signals of impending disaster. Weakness of the eye muscles, the masseters, the facials, the shoulder and tongue may occur without calling for immediate emergency treatment.

The observation, however, of weakness in a single muscle supplied by any cranial nerve should immediately bring to the physician's mind the potential gravity of the patient's illness and hospitalization should be carried out without fail. For transportation an ambulance is needed. Postural drainage of saliva of the mouth is one of the most important aspects of immediate treatment and patients should never be sent to the hospital sitting up. In addition, suction apparatus or a rubber suction syringe should be made available to aspirate the mucus out of the mouth if necessary. Transportation of patients over long distances cannot be recommended and excessive speed with the use of the siren may only excite a patient and make him worse. As Piszczek points out, "the smoothest, slowest ride to the hospital should be used. The patient should not be subjected to any strain or agitation and the patient's morale should be maintained at all times."²

When the hospital is reached, a long history of the case is not of importance and only enough examination should be made to make a satisfactory

diagnosis. Usually the presence of fever, a rapid pulse, a nasal voice, inability to swallow, inability to cough or expectorate, facial paralysis or marked excitement or prostration, are signs of sufficient magnitude to make the diagnosis almost certain. Spinal puncture at this stage should be avoided as it is only likely to aggravate the condition. Patients should be placed in a special bed with solid boards and a hard mattress to give firm support. The foot of the bed should be elevated 15 to 20 degrees.

Tracheotomy. The most important decision to be made immediately is in regard to tracheotomy. If the patient is having a continuous problem in eliminating saliva and bronchial secretions, a tracheotomy should be seriously considered. The maintaining of an unobstructed airway is of first importance; if this cannot be done by postural drainage and aspiration, tracheotomy must be carried out.

The Minnesota Poliomyelitis Research Commission,⁴ a group of physicians who handled 183 patients with bulbar poliomyelitis in the 1946 Minnesota epidemic, present the following criteria which they utilized in a decision on elective tracheotomy in bulbar poliomyelitis: recent onset of bulbar symptoms with evidence of progression of the illness during the period of observation; general appearance of toxicity, especially with high temperature and rapid pulse; progressive difficulties in swallowing or the accumulation of secretions in the throat; and mental changes, especially anxiety, apprehension, hyperactivity, confusion or euphoria in a patient with difficulty in swallowing. The decision, however, is not an easy one and the brilliant results of tracheotomy will be not infrequently offset by total failure. The criteria, however, are sufficiently clear so that this life-saving measure should be carried out promptly.

After tracheotomy, the patient with bulbar poliomyelitis requires expert care and special nurses are needed. It is necessary to continue the aspiration of the accumulation of fluids in the pharynx and the tracheal canula must be inspected and cleared frequently. If the tracheal secretions become viscid, an attempt may be made to humidify the inspired air. The most successful method is to deliver moist air and oxygen mixtures directly into the tracheal tube by a tracheotomy inhalator, a method devised by the Minneapolis group.⁵

Under the general form of treatment outlined above, one hundred patients treated at Minneapolis in 1946, with symptoms limited to the cranial nerves, only five deaths occurred, four of these having taken place before an airway could be secured. The fifth death occurred from aspirated vomitus occluding the tracheotomy and thus all five deaths resulted directly from obstruction of

the airway. The reduction of deaths in this group to below five percent is perhaps the outstanding therapeutic advance in poliomyelitis in recent times and it is based on sound physiologic principles applied to patients with infection by poliomyelitis of the brain stem. Such a result would be impossible prior to the organization of skilled teams for the care of patients with this type of illness, the admission of patients to the general hospitals in the acute stage of the disease, an essential step in the success of the present-day therapy, the availability of special nursing care and the full recognition of the importance of hospitalization by the general practitioner as soon as signs of cranial nerve paralyzes become evident.

(2) *Respiratory and circulatory paralysis.* In addition to involvement of the cranial nerve nuclei in patients with bulbar poliomyelitis, there is still a further group of patients who show respiratory distress based, not upon paralysis of the diaphragm or intercostal muscles supplied by anterior horn cells lying in the cervical and thoracic portions of the spinal cord, but on a central respiratory mechanism controlled by a vaguely outlined center in the medulla. Most of the patients in this group have cranial nerve involvement also. In spite of an adequate airway and with normal or only slightly affected respiratory musculature from spinal centers, in examples of central respiratory paralysis there will be a variation in the rate and depth of respirations with prolonged intervals between inspiration. In addition, patients with this type of bulbar poliomyelitis show anxiety, restlessness, an increasing pulse rate and sometimes an elevation of blood pressure, symptoms attributable to lack of oxygen, although cyanosis is not observed. When failure of the central respiratory system is disclosed, oxygen therapy should be started or increased if already in use. In a patient limited to this type of disorder, the mortality should be considerably lessened by the adequate use of oxygen. Unfortunately, most of the patients with disorders of the respiratory center in the medulla also have various cranial nerve involvements, particularly the tenth nerve for which they need a tracheotomy or cervical and thoracic spinal poliomyelitis requiring the use of a respirator. When all three are present at the same time, the chances of saving a life are indeed small and of the 36 cases classified clinically as belonging to the respiratory-circulatory group in the 1946 Minnesota epidemic, the mortality was nearly 70 percent.

Another group of patients show disorder of circulation as one of the primary signs of bulbar poliomyelitis. Only twelve out of 183 bulbar cases were so classified in the Minneapolis epidemic. The mortality was over 80 percent. The patients

showed a dusky red, florid appearance. The pulse rate was out of proportion to the temperature and ranged as high as 150 to 200; the rhythm was often irregular. Great anxiety and restlessness was always present. Prior to circulatory failure blood pressures dropped to shock levels and the patients expired in delirium, coma or terminal hyperthermia. If the symptoms were at all severe, treatment in this group was unsatisfactory.

(3) *Encephalitic group.* Finally, there are a few patients who develop encephalitic symptoms. The principal indications are anxiety, restlessness and hyper-excitability, muscular tremors and twitchings, irritability and confusion, lethargy, coma and convulsions. When these symptoms first appear, they may be considered as due to lack of oxygen or an unrecognized partial obstruction of the airway. When the airway is clear and adequate oxygen is being received some patients however will show signs of cortical irritation. The group is a small one, the mortality is low and although the symptoms appear alarming, they are of less importance than those produced by collapse of the respiratory or circulatory centers or by paralysis of the muscles supplied by the tenth cranial nerve.

Bulbar and Spinal Poliomyelitis Combined

When patients with bulbar poliomyelitis have in addition symptoms due to spinal involvement, respirator treatment may be required. Special types of respirators have been developed that will allow tracheotomy to be performed while the patient is still being maintained in the respirator. On the severity of the paralysis of the diaphragm and intercostal muscles, often depends the outcome. The prognosis of the combined cases, however, is very grave. Few adults survive; children tend to do better.

Summary

1. Bulbar poliomyelitis has shown a high rate of incidence in epidemics of this disease since 1943. In statistics from various parts of the country about 20 percent of all cases had bulbar symptoms.

2. The fatality rate until recent times was above 20 percent for bulbar cases and over 40 percent for bulbar-spinal cases.

3. In the Minnesota epidemic of 1946, the mortality rate was reduced to five percent.

4. Rapid diagnosis, intelligent transportation to hospitals, the use of general hospitals, teams of physicians and nurses, tracheotomy, oxygen, adequate drainage and the use of the respirator were factors in the favorable fatality rate.

5. No community is immune to poliomyelitis. All should be "alerted" if the fatality rate of bulbar

continued on page 450

THE CHALLENGE OF MEDICINE IN THE ATOMIC ERA*

EDWARD L. BORTZ, M.D.

The Author, *Edward L. Bortz, A.B., M.D., F.A.C.P., LL.D.* of Philadelphia, Pa. (President, American Medical Association, Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania; Member, Board of Governors, American College of Physicians; Honorary Consultant to the Surgeon General of the U. S. Navy.)

IT is a high privilege and honor to be your guest on the occasion of the One Hundred and Thirty-Seventh Annual meeting of the Rhode Island Medical Society. The medical profession in this beautiful New England setting is rich in tradition and large in accomplishments. You are regarded as one of the progressive and far-visioned Societies of our great land. Your Scientific Program at this Meeting is filled with discussions of topics of major importance, and your speakers are recognized authorities.

Medicine Today

It is my purpose this evening to consider with you the status of medicine today and survey a few of the trends appearing in the work of our profession.

The expanding frontiers of medical science have yielded insight into the nature of many of the disorders and diseases which beset mankind. Even before the war, use of the scientific method and well integrated programs in the various fields furnished new information about various kinds of infections, nutritional disturbances, glandular conditions, cancer, and the degenerative processes of the body. Military necessity mobilized scientific talent in particular directions that greatly accelerated the speed of discovery. For example, fractionation of the blood as developed by Cohn of Harvard, and the greatly augmented use of plasma and blood substitutes served to reduce the mortality rate of wartime casualties. While the development in the field of infectious diseases was well on the way before the war, the improvement in methods which took place during the war and afterward are preserving lives which earlier would have been snuffed out rather promptly.

* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, May 12, 1948.

Knowledge in the field of nutrition, with reference to the usefulness of the various vitamins, has opened new fields of investigation. We now possess a fund of information of lasting value about the specific nutritional needs of the body. Discoveries which have revealed the chemical nature of the steroids, and the close relationship chemically of substances which are important in the glandular activities of the body, have opened new fields of scientific inquiry. Indeed the world of medicine has derived rich benefits from the application of science in the realm of disease control.

The atomic age now starts a new chapter in man's study of man and his infirmities. With the increasingly effective control of those disorders which in earlier years had exacted a high mortality rate, science may focus its abilities on fields that up to the present have not been explored. With life-saving measures which have reduced maternal and infant mortality and protected youth from the ravages which earlier were so destructive, a larger percentage of the population is growing into years in which the degeneration of body tissues commonly takes place. While cancer, too, is likely to appear in any group, it is most common in the mature periods of life.

Atomic Elements of Medical Importance

While the attention of the public is daily being confronted with reports concerning the military applications of atomic power, the utilization of radioactive isotopes is blazing new trails in the realm of biology. Even the vocabulary of medicine is being changed with such rapidity that one finds difficulty in keeping abreast of medical activities. This is a healthy sign, and a stimulating challenge to medicine as a learned profession. Einstein has stated that "The atomic era makes it necessary for us now to think in new terms." This statement has an especial application for medicine. It may well be that the benefits from the intelligent and humanitarian application of atomic power will become so attractive to all people that its use as a force for human destruction may sink into oblivion. With the use of the magic bullets — the isotopes — concerning which every physician should inform himself, our understanding of the physiological processes of the human body may be greatly expanded. Also, with these new elements, a better

conception of the early deviations from normal growth, at which point in cellular activity within the body a cancerous tendency is initiated, may be more readily identified. Premature tissue deterioration is a subject of immense importance to the medical profession since many people are becoming victims of this condition as they grow into the mature years.

The earliest lesions of atheromatosis now appear to result from a disturbance in the intermediary fat metabolism of the body. For example, it can be proven experimentally by feeding animals large quantities of fat that fatty degeneration beneath the lining of blood vessels commonly occurs. At present we do not know exactly how this takes place, although there are certain attractive hypotheses which have been offered to explain the deposition. With the introduction of tagged atoms into fat molecules, more information should be gleaned of the little understood intermediary steps which lead to the precipitation of fat within the walls of blood vessels. This represents the first lesion, so far as we know today, of deterioration in the vascular system. The magic bullets should give medicine a new weapon to combat the common disease of arteriosclerosis. And here let me emphasize again the fact that growing old of itself is not a disease. There are many older folks whose blood vessel systems are comparatively free from the degenerative lesions of the vascular system. Arteriosclerosis is not an essential accompaniment of ageing. It can be prevented experimentally in lower animals by the marked restriction in the fat intake in the body. Researches in the field of vascular disorders are of vital importance to our nation since lesions of the blood vessels destroy more than 600,000 lives a year. Circulatory diseases killed four times as many people as were destroyed by cancer in 1947. It is high time that a greater percentage of the funds expended in the fields of medical research be directed into channels which are probing for the secrets of tissue degeneration.

Curiously, the more we learn about tissue degeneration and tissue repair, the more we will learn about the fundamental nature of cancer because normal growth and normal tissue repair are governed by the physiological laws of living cells. In this realm should ultimately be found the basic nature of the abnormality which becomes the cancerous growth.

It is my belief that, during the next quarter century, science will extend the boundaries of our knowledge and understanding of the basic natural laws which govern the psychological processes necessary to human existence. As we learn more about

intermediary metabolism, refined methods for control of these distortions and deflections from the normal will appear.

It is safe to conclude that the atomic era offers rich promise for wider understanding of the physical maladies of the human body. When the major destructive processes which now are responsible for the loss of three-quarters of a million lives each year are brought under control, a further substantial increase in the life span will become evident.

Problems of Personality

Diseases of man's physical body are yielding to improved methods of management. But man is more than a physical mechanism, a transformer of energy. It is a curious fact that, at a time when our control of infections, our understanding of glandular and nutritional disorders, and our insight into other problems of the physical body have brought us remarkable control over these diseases, some fifty-seven percent of hospital beds in our nation are taken up by patients with psychiatric and nervous disturbances.

Someone has said that the higher the civilization, the longer the shadow it casts. Man's inability to adjust himself in the face of industrial and material progress has placed a great strain on large numbers of our fellow citizens. Nevertheless, substantial progress has been made in our understanding of mental disorders, and I believe that science will ultimately find better methods for the identification of incipient deviations from the normal. Then more adequate measures for prevention, control and repair may be predicted.

New Frontiers

The distinguished Roger J. Williams some time ago stated, "We are in the ox-cart days, so far as the utilization of human resources is concerned." And the beloved Walter B. Cannon whom you all knew many years ago, introduced new methods of investigation which dealt with rage, fear, and the competitive instincts of animals. He stressed the need for a wider and, at the same time, a more concentrated approach to the study of emotional problems. Here is one of the important new frontiers. For are not men creatures of moods and fancies, hopes, fears and aspirations?

In the new era, science has come upon astounding sources of energy which, if correctly harnessed, may furnish all the nations of the world with sufficient power to carry on their industrial productive programs with no hint of serious depletion. And medical science is extending the span of life and adding more health to the later years, especially in communities and nations where modern methods

continued on next page

of disease control and prevention of disease-spread is in common usage. In this new day, because of man's inability to understand himself and his fellow man, and to fashion a social program that will offer each individual optimum opportunity for self- and social-development, an ominous darkness threatens to engulf humanity.

It was Descartes, I believe, who made the statement "If ever mankind is to develop and grow materially, culturally and spiritually, medical science will perform that service." Now that success has crowned the efforts of science to control the denizens of the microcosm, that is the inhabitants of the bacterial world, we need to direct our attention more and more to logical procedures that will give us equally clear visions of the emotional and social problems which are causing such a vast amount of unhappiness in the world.

Social Medicine

Organized medicine has three major objectives, namely, medical education of a continuing high order; education of the public, and extension of the benefits of modern medical science to all the people of our land, and third, medical research.

In the field of medical education, some pressure has been brought to bear to have medical schools increase their output of graduates. Statements have appeared on the shortage of physicians. It must be admitted that there is a maldistribution. But within the next five to eight years some twenty thousand young medical graduates now in process of intern and residency training will be seeking positions and areas where they may establish themselves in practice. Basically, as a nation, we should have, not more physicians, but fewer patients. As the medical profession conducts an educational program stressing prevention and the maintenance of a high level of health education which should be taught in all schools, morbidity rates will show some decline.

The problems of the distribution of medical service are now under critical scrutiny. The Bureau of Medical Economic Research with its capable director, Frank D. Dickinson, Ph.D., is performing an excellent service to the nation by charting medical service areas in several of the states. In this study now going on, medical needs of each community in these states are being plotted against the supply of professional personnel available. Therefore, for the first time, a basically unemotional, strictly factual study of the medical needs of the people is being conducted by a Director whose corps of able assistants are in search of the truth, with no aim to support any particular point of view.

Medicine is a social profession. The daily routine of each physician is a contribution to the social welfare of his community. The medical literature now is again replete with considerable discussion of the social phases and psychosomatic problems. Yet there is nothing essentially new or unique about this development. The philosophers centuries ago weighed the influences of heredity, environment and the influences of social mores on community life.

The Challenge to Medicine

The medical man is particularly fitted by instinct, training and experience to evaluate the influence of the social atmosphere on the welfare of patients. However, physicians too often fail to accept their full responsibility as citizens. As a profession, we are willing to forfeit the conduct of civic affairs not infrequently to vocal representatives of pressure groups bent on preferential consideration for powerful political minorities. In this circumstance, society finds the root of the social cancer which, when uncontrolled, has overthrown democratic peoples and shackled other nations with a form of government inimicable to the best interests of their homeland.

Medicine as a humanitarian profession must awaken to the importance of its great social obligations. The medical profession is dedicated to the support and protection of human life and the elevation of the human intellect, to the preservation of individual freedom. These objectives offer the greater opportunity for the flowering of the human spirit. Our profession must join with other humanitarian groups to combat the forces of a government which threatens to enslave mankind.

We are opening a most exciting new chapter in world history. Never has medical science — never has the practicing physician had the opportunity to render such superb personal and social service to his community. As a profession, we need to be stirred to greater action and play a larger role. Important problems are before the American people. Our fitness as a nation to survive will depend on the understanding with which we as a people solve these problems. Our destiny as a nation depends on the program which we must develop that will bring encouragement and hope and a new interest in living for the stricken people of the world. May we rise to our full power and help to guide the destiny of man in the atomic era to a better day for our fellow men. Medicine has a dominant role to play. Let us be on our way.

A NEW TECHNIQUE IN THE RADICAL CURE OF HYDROCELE*

VINCENT J. ODDO, M.D., F.A.C.S.

The Author, Vincent J. Oddo, M.D., F.A.C.S., of Providence, Surgeon-in-Chief, Urological Department, St. Joseph's Hospital.

MANY FORMS of treatment have been advocated for the cure of hydrocele. Tapping of the hydrocele, or tapping with the injection of a sclerosing solution into the tunica vaginalis sac, have a large number of adherents. There is no doubt, that in some cases excellent results have been obtained by these procedures, but it is equally true, as statistics indicate, that a certain number require repeated tappings and injections.

However, at the present time, the majority of surgeons prefer the open operation. Different techniques have been proposed for the repair of hydrocele simply because no single method has proved entirely satisfactory.

Winkelmann advised only partial excision of the sac, eversion of the proximal portion of this sac, and suturing the edges posterior to the epididymis. In this operation, great care must be exercised to prevent hemorrhage and resulting hematoma.

Andrews 'bottle operation', consists of opening the tunica vaginalis sac, turning it inside out, and suturing it behind the epididymis. It is a simple procedure and probably the most commonly used. Its disadvantages, however, are that it leaves a large mass of tissue behind the testicle, there may be occasional recurrences, and frequent and extensive hematomas. So in these cases, meticulous care needs to be used in the clamping and ligation of all bleeding vessels.

In the Van Bergmann technique, all of the parietal layer of the tunica vaginalis is excised.

Volkman, after incising the tunica vaginalis and suturing the edges to the scrotal skin, wipes the cavity with carbolic acid and then packs it with gauze. The sac is then allowed to heal by granulation.

Klapp, instead, substitutes the reefing of the tunica vaginalis for the eversion.

In 1940, Hugh H. Young, described a new technique for the radical cure of hydrocele, by excision of the serous layer of the tunica vaginalis. Several cases were reported with uniformly good results.

Croot described an operation in 1944, in which, after the tunica vaginalis is everted and the dartos and skin approximated, the scrotum is anchored to the abdomen. He states that with this method, the post-operative swelling of the scrotum is eliminated.

The purpose in all of these techniques is either to excise the tunica vaginalis or attempt to obliterate the endothelial lining of the tunic.

Several years ago, the author felt that the operation for the radical cure of hydrocele could be very much simplified by utilizing a new physiological principle. It has always appeared to me that a hydrocele formed because of an injury to the endothelial cells of the tunica vaginalis, with a consequent outpouring of an effusion. This injury could be ascribed to trauma or to an infective process. (Plates 1-2-3)

Several years ago, the author felt that the operation for the radical cure of hydrocele could be very much simplified by utilizing a new physiological principle. It has always appeared to me that a hydrocele formed because of an injury to the endothelial cells of the tunica vaginalis, with a consequent outpouring of an effusion. This injury could be ascribed to trauma or to an infective process. (Plates 1-2-3)

PLATE 1



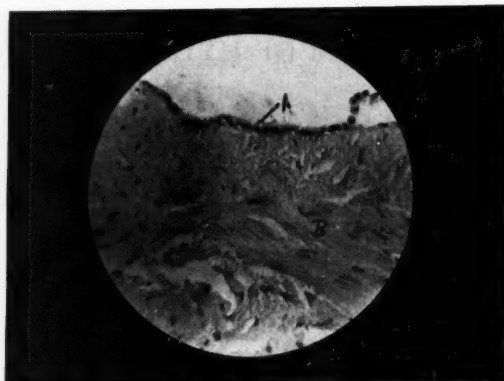
Low power—showing a cross section of the tunica vaginalis, in a patient, aged 52 years, who suffered two years with a hydrocele.

- (a) Enlarged endothelial cells.
- (b) Increase in fibrous tissue.
- (c) Artery, showing leucocytic infiltration.

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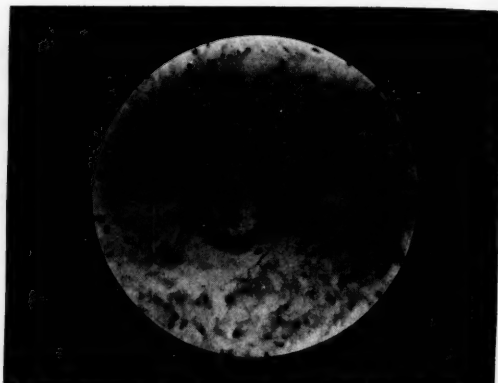
* Presented before the Providence Medical Association, at Providence, April 5, 1948.

PLATE 2



High power—The endothelial cells (a) are hyperactive; they are very large and swollen, cuboidal to columnar in shape; nuclei are very prominent. There is an increase in fibrous tissue (b) beneath the endothelial lining.

PLATE 3



High power—Demonstrating an artery with perivascular leucocytic infiltration. All of these changes in the tunica vaginalis are consistent with a mild chronic inflammatory process.

During the past three years, the following technique has been followed in eighteen cases. The smallest sac contained one ounce of fluid, the largest thirty-six ounces. There were neither recurrences, nor complications of hemorrhage or hematoma. There was one death, in an elderly patient, aged seventy-nine years, from coronary embolism.

The drawings by William P. Didusch very graphically depict the various steps of the operation, and therefore, little descriptive text is necessary. (Plate 4) (Figures 1-5)

As shown in figure 1 the sac is grasped and put on tension. An incision beginning at the lower and extending to the upper end, was made thru the skin, subcutaneous fascia and dartos, down to the tunica vaginalis. The tunic is now freely separated from the dartos in a circular manner for a distance of about one inch.

In figure 2 the tunic is opened, the testis and epididymis are examined.

In figure 3 the edges of the tunic are everted about one quarter of an inch, and sutured to the external layer of the tunic with interrupted plain catgut. Thus a permanent opening is made in the tunic, the lining of which is made up of endothelial cells. This aperture cannot become occluded because the raw edges of the tunic have been everted.

In figure 4 a section of the scrotum is shown.

In figure 5 a rubber drain is placed into the sac, the dartos is closed with chromic catgut, and the skin with silk.

The scrotum is then enclosed within a gauze pad, and an adhesive bandage applied tightly. The drain is removed in twenty-four hours, and the skin

sutures in three or four days. The patient is advised to wear a suspensory bandage for a while.

EXCERPTS FROM CLINICAL NOTES OF SEVERAL CASES

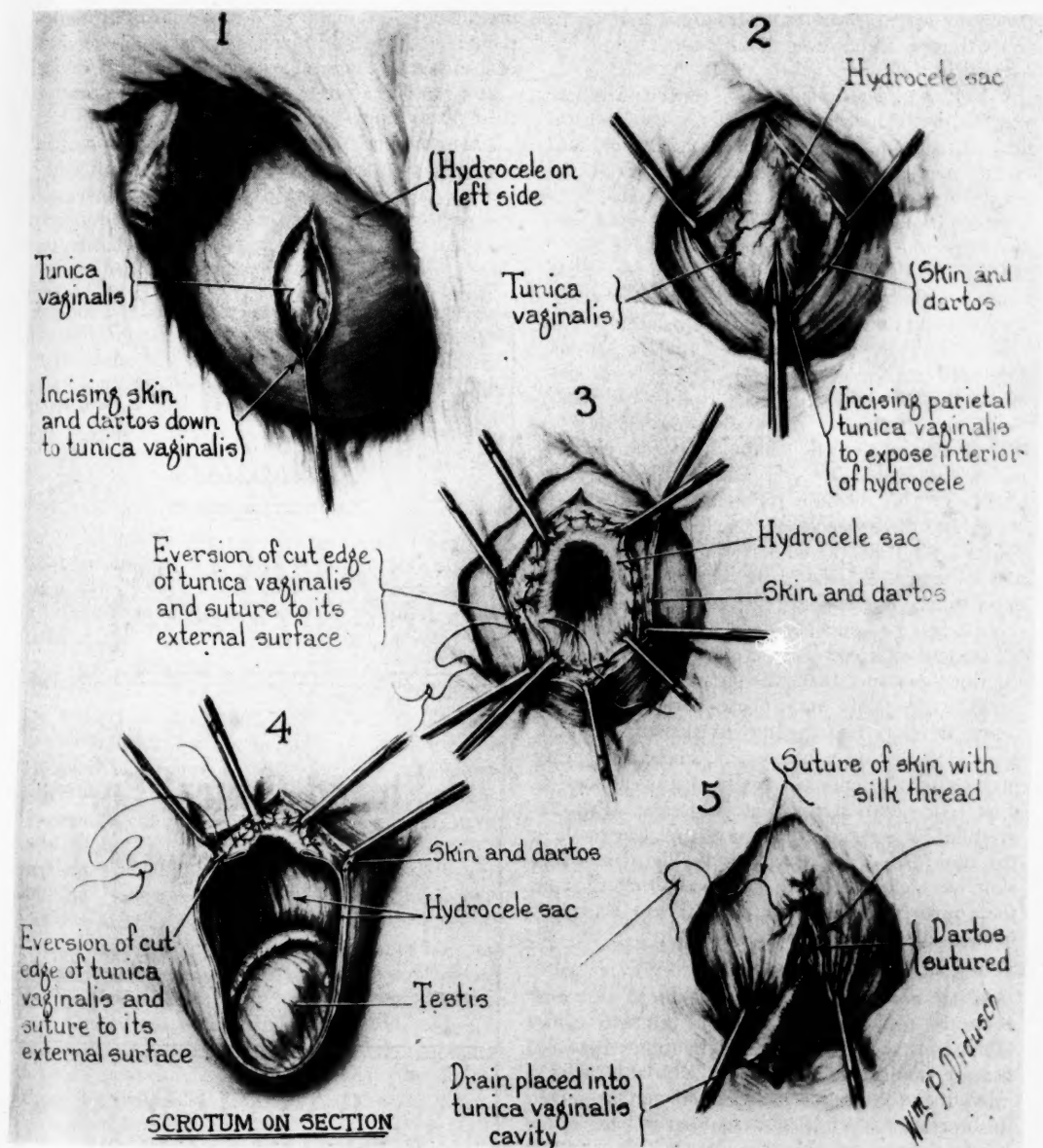
CASE 1—The Patient complained of an ache in the right scrotum. A hydrocele of medium size, containing three ounces of clear, straw colored fluid were found. A smaller hydrocele was present on the left side, which did not cause any symptoms. In this case an aperture was made in the tunica vaginalis on each side.

CASE 2—This patient, aged 74 years, developed a right hydrocele after a fall down stairs twenty years previously. He complained of a sensation of weight in the right scrotum. Six ounces of fluid, clear and straw colored were removed. An aperture in the tunica vaginalis was made. The patient was seen recently and the tunic contained no fluid.

CASE 3—This case complained of pain and a sense of weight in the right scrotum. At operation, sixteen ounces of clear straw colored fluid were removed. An aperture was made in the tunica vaginalis. The swelling in this case did not subside for one month. However, now there is no fluid present.

CASE 4—This little boy, aged three years, had a swelling of the left scrotum. The mother was alarmed and desired immediate treatment for her son. Six months ago, the boy fell from a chair, and the swelling in the scrotum was found soon afterwards. At operation, one ounce of clear straw colored fluid was removed. An aperture was made in the tunica vaginalis.

PLATE 4



Showing the method in the new technique for the radical cure of hydrocele.

CASE 5—The scrotum in this elderly patient, aged 65 years, was tapped six months previously; and since that time, the swelling became greater and more painful. The scrotum could not be transilluminated. At operation, two ounces of bloody fluid were obtained. This was probably the result of the tapping. The inner surface of the tunica was pale, and roughened; the parietal and

visceral layer of the tunica vaginalis were much thickened. The testis was atrophic. Castration was performed. The biopsy showed that the testis was still active and healthy. This testis could have been saved by making an aperture in the tunica vaginalis.

CASE 6—In this patient, aged 45 years, there was a complaint of an ache in the left scrotum. Two and one-half ounces of clear straw colored

continued on next page

fluid were obtained. An aperture was made in the tunica vaginalis, no drain was inserted, and the dartos and skin closed tightly. This was done purposely to see whether the hydrocele would recur. Since the operation, seven months ago, no fluid has formed in the tunic.

CASE 7—The right scrotum in this fifty-five year old individual was fairly big, caused a great deal of pain and a sense of weight. It contained twenty-five ounces of clear straw colored fluid. An aperture was made in the tunica vaginalis. The scrotum healed rapidly. Since the operation two years ago, the patient has been comfortable.

CASE 8—This elderly male, aged 79 years, was rushed to the hospital because of acute urinary retention from an enlarged benign prostate. A cystotomy was performed under spinal anesthesia. The patient also suffered from a large hydrocele on the right side for the past twenty-five years. Seven days following the first operation, the hydrocele was repaired by making an aperture in the tunica vaginalis. Thirty-six ounces of fluid were obtained. On examining the testis, a hydrocele containing three ounces of clear colored fluid was found behind the globus major. This was opened and an aperture made in the same way as in the outer tunic. The patient progressed well for three days, when he suddenly developed coronary embolism and expired. The scrotum was dressed on the third day and there was no swelling.

CASE 9—This very obese patient, aged 52 years, developed a swelling of the left scrotum soon after lifting a heavy pail, about two years previously. A sense of weight disturbed the patient. At operation, two ounces of clear straw colored fluid was removed. An aperture was made in the tunica. No drain was used. The dartos and skin were closed tightly. He was discharged on the fourth post operative day. There was very little swelling in the scrotum.

SUMMARY

It has not seemed practical to me to excise or evert the tunica vaginalis behind the testis, since in most instances, the lining of the tunica appeared healthy on inspection. It was with this idea in mind that the author has devised and presented this operation. While it is true that this technique has been done on a small number of cases, it still deserves consideration by the medical profession.

With this technique, which could be called the formation of a window in the tunica vaginalis, the anatomical relationships of the tunica and testis are not disturbed, the testis is still surrounded by a small amount of serous fluid, and does not become adherent to the surrounding tissues, as in all other operations. While the purpose of other methods of treatment has been to excise or obliterate the endothelial lining, with this new technique, the aim

is to preserve and protect the endothelial cells of the tunica vaginalis. In the operative procedure, the edges of the opened tunica vaginalis are everted, producing a permanent aperture lined by endothelial cells. The fluid which is formed subsequently, is absorbed by the capillaries and lymphatics of the dartos, until the cells of the tunica vaginalis resume their normal physiological function.

Cases number six and nine, for example, in which the dartos and skin were closed tightly without drainage, demonstrate the absorbent powers of the dartos. It is felt, that, once the continuous pressure in the tunica is removed, the chronic inflammatory process subsides, with no further outpouring of an effusion.

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FUNDAMENTALS OF STAFF ORGANIZATION*

CHARLES F. WILKINSON, JR., M.D.

The Author, *Charles F. Wilkinson, M.D., of Ann Arbor, Michigan. Coordinator of Graduate Medical Education, University of Michigan, Ann Arbor.*

IN ORGANIZING a staff for a hospital, a great deal will depend on the size of the hospital, whether it is connected with a University, affiliated with the University, or strictly independent of University connections. It will also depend on whether the staff is full-time at the hospital or if the majority of the staff are employed in full-time practice.

Let us consider first, the hospital of 100-150 beds which is staffed by practicing physicians whose primary interest is in their private practice rather than in teaching medicine. Here, the staff organization will be relatively loose and the staff will be quite large. The chief of staff and heads of the various services may change from year to year and such a position may be awarded to an older man in recognition of service rendered to the hospital and the community. Such a man may not have the time to devote to teaching nor may he have the inclination. In a staff such as this, it is wise to have an educational committee composed of younger members who are interested in teaching the intern and resident staff and who have the enthusiasm and the time to devote to this. This educational committee should be responsible jointly to the chief of staff and to the chief resident physician or hospital administrator so that there will be no conflict between routine duties of the resident staff and the time allotted for their instruction. It should outline broad programs which will then be implemented by the chief of service whose responsibility it is to see that individuals are available for different teaching assignments.

The problem is more simple in a university hospital where it is assumed that a large number of the men are full-time. Here, we have a group who are devoting their lives to teaching and it is to be assumed that a teaching schedule will be worked out in close connection with that of the medical students, so that all the facilities of the university are available to the resident staff.

Here again, however, there must be close cooperation between the administrative branch and the professional branch of the hospital so that neither group will feel that it is being deprived of its just share of the resident staff's time.

In a third intermediary group of hospitals, we will find hospitals that are not university hospitals, but affiliated with a university. This group may expect varying degrees of cooperation to aid in their teaching program.

In many of the above-mentioned types of hospitals, the professional and administrative staff will parallel each other, but should have closer liaison so that the functions of the hospital—(1) care for the sick, (2) to continue the physician's education, and (3) research—may be carried out.

Elements for Ideal Practice

At this point, it might be well for me to emphasize the fact that the ideal practice of medicine is made up of these elements: namely, (1) The care of the sick; (2) The teaching of the art and science of medicine; and (3) Research in either the basic medical sciences or clinical investigation. We must not consider a hospital as an institution where only diagnoses are made, operations performed, and drugs administered. It must become the educational center of those doctors who work and practice therein.

It is then, the function of the visiting staff to act as counsellors for the young members of the profession (resident and intern group) and also to take part in their own continued medical education. If they are private practitioners the major part of their time will be spent in the care of the sick, but many feel that if they do not devote some time to instruction of interns, residents and nurses; that if they do not participate in various medical educational ventures such as meetings, etc.; they will eventually not be able to fulfill their primary objective (the care of the sick) to their full ability. It is often said that medical research is the prerogative of a special individual. I feel this is not so and that any hospital can offer facilities of some degree for original research. And even though this research does not result in earth-shaking publications, a philosophy is developed and mental habits are formed that are associated with the highest type of medical practice.

continued on next page

*Presented at the Third New England Institute for Hospital Administrators, at Brown University, Providence, on June 25, 1947.

The intern and resident staff should be so organized that there is an increasing responsibility and an increasing willingness to assume this responsibility. They should be encouraged to engage in small research problems and to attend all meetings of the hospital, even some of the administrative staff meetings. If this is done, they will be far more sympathetic with the problems of the director. The intern is not a slave and should be given sufficient time for recreation and study. It is only when a service staff is highly organized so that responsibility can be delegated and shared that the intern will be able to have this time available.

Division of Services

I have mentioned above that the hospital staff should be divided into services. The Michigan State Medical Association recommends that, in addition to the usual services of medicine, surgery, etc., there be a Service of General Practice. This general practice service is organized with the Chief of Services, associates, etc.; however, the patients are usually admitted according to their diagnosis on one of the other services. When the general practitioners are organized into their own service, they can be of great value in teaching programs and feel that they have a voice of their own, and in the hospitals with which I am acquainted where this type of organization exists, it has worked out admirably. It might be asked why it is necessary to divide a hospital into services. To a physician, this seems self-evident; to the lay person, it is frequently not. However, in this age of specialization, better medical care can be given when patients are grouped according to the type of condition that affects them, for here we can employ nurses with training in special techniques; the resident staff will be attending to one general type of patient only, and many laboratory and special procedures that are normally used for a certain type of patient can be made more available to that patient.

How should the nursing staff fit into the picture of hospital organization? At the University of Michigan, nursing is considered a separate school and is organized as a third parallel staff within the hospital. The chief nurse is responsible to the Dean of the Medical School as Professor of the School of Nursing; she is responsible to the various service chiefs to see that the best possible nursing service is rendered within his department. She is also responsible to the Administrative Director of the Hospital in manners that affect him. This is truly a large bill for anyone to fill and requires a person of unusual ability. In small hospitals, the chief nurse will come directly under the hospital administrator, and as such, will be saved much of the ad-

ministrative detail found in larger nursing schools. In order that a hospital staff will function smoothly, it is necessary that the duties of each individual be outlined so that responsibility can be placed for various details in the care of the sick individual. It should be outlined carefully the duties of the intern, assistant resident and resident; the visiting staff should be informed of their obligations to the hospital as well as their privileges, and in small hospitals these obligations may be considerable. For instance, the hospital which cannot attract an intern or resident staff must depend on the attending physician for history, physical examination, progress note, and the proper diagnosis and summarizing of the case after discharge. I do not feel that any of this should be relegated to the nursing staff, though this is not infrequently done. The physician should have in his office, records showing a history and physical of the patient; a copy of which can be transferred to the hospital chart if he does not have time to do these again after admission. Certainly no one but the attending physician can properly record the clinical progress of the patient. Only he, or his assistants, can record the operative note in sufficient detail, and final diagnosis is of course his obligation. This does not mean that the nursing staff does not have a large responsibility in recording their own progress notes. These are most helpful and are more detailed in some respects than the physician's progress notes. These supplement each other, and neither can be omitted without detriment to the patient.

In hospitals of any size there will be many policy-forming groups and these should be represented by both the administrative and professional branches of the hospital. Here again, we are faced with the fact that only by the closest cooperation between these two groups can the hospital give its maximum service. In formation of the budget the professional services should be represented so that they may offer guidance in certain technical matters, such as the purchase of equipment and drugs. On the other hand, the administrator may reasonably expect to standardize certain procedures and even prescriptions, so that he will not be forced to duplicate material which differs only in name.

The Organization of a Service

Let us take one service and look at it in a detailed manner rather than in the general way we have covered the hospital before. First, there will be a chief of service and under him associates, assistants, residents, assistant residents and interns. The Chief of Service will have more or less autonomy depending on his tenure, depending on whether he is full-time or part-time, and many other factors. He is, however, responsible to the

continued on page 454

The RHODE ISLAND MEDICAL JOURNAL

*Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island*

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TREATMENT OF BULBAR POLIOMYELITIS

THE FIRST PAPER in this month's JOURNAL is the communication by Viets of Boston to the recent annual meeting of the Rhode Island Medical Society, entitled "Neurologic Aspects of Poliomyelitis".

Editorial attention is called to this contribution because of the serious new problem which is presented. Viets has found that in the recent epidemics of poliomyelitis from 1943 to 1946 there has been an alarming increase in the proportion of cases with bulbar involvement. In the scattered epidemics these cases have amounted to over 20% of the total. In the purely spinal types the improved methods of treatment have reduced the mortality to about 1%. The bulbar cases on the other hand have shown a mortality averaging over 20%.

Viets found that the reports from Minnesota based on 100 such cases in the 1946 epidemic showed an extraordinary reduction in this mortality to 5%. Up to the present of course no known specific treatment for poliomyelitis has been found. The great reduction in mortality has resulted from careful application of certain principles of treatment which Viets outlines in the present paper.

In the first place all cases of poliomyelitis, including suspected cases, should be watched very

carefully for evidence of weakness in any of the muscles supplied by the cranial nerves. This requires no complicated apparatus or special tests; merely careful use of the ordinary senses applied to clinical observation.

Attention should be paid to sudden increase in rapidity of pulse, nasal voice, difficulty in swallowing, inability to cough or expectorate, facial paralysis, oculomotor paralysis, speech disturbance, etc.

Any of the motor cranial nerves may be involved. While many of the resulting symptoms may appear alarming, most of them are of relatively minor importance. However when the 10th nerve is involved the patient's life is primarily endangered.

The general practitioner who first sees the case is the man upon whom rests the greatest responsibility in attempting to reduce the mortality in these cases. He must not wait until he finds definite signs of 10th nerve involvement. Viets believes that observation of weakness in a single muscle supplied by a cranial nerve should be the warning signal. The potential gravity of the case should be recognized, and the patient should be immediately hospitalized.

Transportation to the hospital should always be

continued on next page

by ambulance, and never with the patient sitting up. Rapid speed of transport, with police escorts and screaming sirens must be completely discarded. The slowest, smoothest possible trip is the most desirable, with the minimum of physical and mental strain for the patient. During the trip the airway should be kept unobstructed by postural drainage of saliva and mucus, with aspiration if necessary.

On arrival at the hospital a waiting team of physicians should be ready to perform immediate tracheotomy if the simpler means have not been satisfactory. When the operation is done, it should of course be followed by skillful aftercare and special nursing.

Oxygen will often be necessary if there is anxiety, restlessness, increasing pulse rate, elevation of blood pressure or other signs indicating lack of oxygen. Sometimes these signs may be due to involvement of the deeper medullary centers which control circulation or respiration. In these cases of course the prognosis is much graver.

A combination of bulbar and spinal infection has

a still higher mortality, up to 40%. In these cases the respirator should be used early.

This situation has been stressed editorially at the present time in order to "alert" the general practitioner to the serious importance of recognizing the early signs of bulbar involvement, well in advance of the seasonal recurrence of the disease, which does not take place of course until late summer and early fall.

In short, Viets emphasizes the importance of early hospitalization in the bulbar cases, keeping the airway open, prompt tracheotomy, early use of oxygen, and possibly the respirator.

He feels that these cases should be treated in general hospitals, where skilled teams and trained personnel should be ready. This will of course require a complete reversal of the present policy in most of these hospitals with respect to the admission of cases of poliomyelitis. Viets however insists that the general hospital must open its doors to these cases if continued good results and sustained reduction of mortality are to be expected in the future.

GUY WILLIAM WELLS

1891-1948

THE death of Guy W. Wells, on June 15, 1948, has taken from the medical profession of Rhode Island one of the outstanding physicians of his generation. With his natural gifts for leadership and friendliness he will be sorely missed, the more because of his going just when he had reached the peak of his active career.

Though a native of Pennsylvania where he received his early education, much of Dr. Wells' life was spent in Providence. After his graduation from Brown University in 1916 he gained his medical education at Cornell University Medical School, returning to Providence in 1920 as an intern at the Rhode Island Hospital. After two years of additional training as a resident physician at the Peter Bent Brigham Hospital in Boston he came back to Providence to enter the practice of internal medicine. Immediately he began an active participation as a visiting physician in the hospitals of the city to which, throughout his career, he devoted much earnest, energetic and conscientious service. One of his great interests in Medicine was in bettering patient care in hospital services and he gave generously of his time to both the outpatient and ward services of the Rhode Island, the

Chapin and the Lying-In Hospitals, and to the Memorial Hospital in Pawtucket. During the last two years of his life he served as chief of the medical service in both the Memorial and the Rhode Island Hospitals.

Dr. Wells' interests in the field of Internal Medicine were general rather than specialized, though he gave particular attention to thyroid and other endocrine disorders, to cardiovascular disease and, in his later years, to diseases of the liver. While at heart he was a clinician, and in practice a very thoughtful and practical doctor, endowed with sound judgment, human understanding and that rare gift of common sense, yet he loved the study of physiology and the basic functions of the body. One often heard him advising younger doctors to keep up their grounding in basic sciences, a practice which he himself greatly enjoyed following whenever time for reading and study came his way.

Few doctors encumbered with a busy practice of medicine have given as liberally of their time and energy as did Dr. Wells to the work of their local and state medical societies. He served from 1936 to 1941 as secretary of the Rhode Island Medical Society and during 1947 was president of the

Providence Medical Association. For a number of years he was a member of the House of Delegates of the state society and both before and after World War II served as the member from Rhode Island to the House of Delegates of the American Medical Association. He was active also on many committees of both the local and state societies. To all of these offices he devoted conscientious time and thought. They were not to him titles of prestige and importance, but appointments that called for study and action.

The same zeal that characterized Dr. Wells' devotion to Medicine, to his patients, and to medical societies, stood out in his allegiance to his country. He was conspicuously a patriot with a deep interest in all that true patriotism calls for. Soon after entering practice in 1924 he joined the Medical Reserve Corps of the Army as a first lieutenant, and by study and periods of training rose to the rank of major in that organization. In July, 1941, he was called to active duty, being made Chief of the Medical Service of the Station Hospital at Camp Devens, Massachusetts. For a period in 1942 he was assigned to special duty for the procurement of medical officers in Rhode Island, and then, with the activation of the 52nd Station Hospital, to that unit as Commanding Officer. His was among the first units to land in North Africa after the invasion, and there his hospital, located in Oudja, had a distinguished record throughout the African campaign. With the invasion of Italy, the hospital was moved to Naples. Dr. Wells remained at its command through all the months of the Italian campaign and made of it an organization whose spirit and record was one of distinction. On release from active duty after the war he continued his leadership in the Organized Reserve Corps of the Army by building up a Hospital Ship Complement in Providence. It is appropriate to quote here, as a tribute to his devoted service and patriotism, two messages from his superior officers sent to his wife on learning of his death:

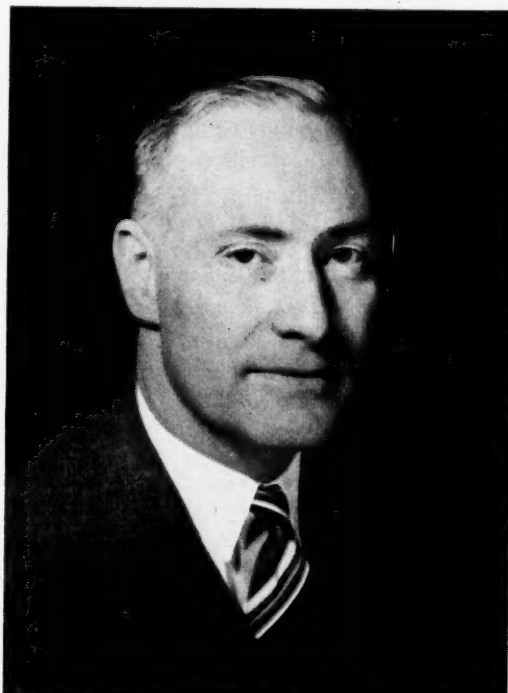
From General Mark Clark:

... His unselfish devotion to duty during our campaigns in Italy endeared him to us all. Together with his countless friends I salute the passing of a loyal soldier and a real friend to man. . . .

From Brig. Gen. J. J. Martin, MC., U. S. Army:

... American medicine and particularly the Army, which he loved so much, have lost a pillar of strength which can never be replaced. As a doctor, a military leader, and a gentleman he had no peer. The many thousands of his comrades who were carried through the trying days of the last war by his unfailing cheerfulness and his uncanny ability to lead the way to the best horizons will bear into eternity the mark of his presence. . . .

One of Guy Wells' great gifts was his genuine capacity for friendship. He was endowed with that kind of warmth of greeting and sympathy that attracted people naturally and his friends were legion, their devotion to him great. Everyone liked Guy Wells. One could not escape knowing the force of his convictions or annoyances for he voiced them freely, with earnest emphasis and with carefully considered reason, and almost always with a smile. He was outstandingly a gentleman; tolerant and considerate of the feelings of others. He could accept an opposing view that to some would bring irritation by a serene dismissal, "Well, that is very interesting",—yet there was no lack of "righteous indignation" in his makeup, and he would not hesitate to voice it when it was called for. In all of his positions of leadership it was invariably his way to seek counsel from those under him and make them feel they shared leadership with him. The iron hand of authority was as foreign as friendliness and co-operation were natural to him, and a smooth running organization was the result when he was in command. With all of his interests and accomplishments he was very much a family man. No one was ever more devoted to his home and his family nor took greater pride in his household and his children. The world can ill afford to lose men of the stamp of Guy Wells.



GUY W. WELLS, M.D.
1891-1948

GENERAL SESSION

THE RHODE ISLAND MEDICAL SOCIETY

May 13, 1948

PRESIDENT RUGGLES: The by-laws of our Rhode Island Medical Society provide that during the Annual Session, there shall be at least one general session at which any members of the Society may present any business of concern to the profession. I declare this to be the general meeting of this session, and at this time I am going to ask our Secretary to report on the list of officers.

SECRETARY CUTTS: As there have been regular reports throughout the year to the House of Delegates on the business of the Society and on the meetings of the Council, this report will be limited to reading the names of the officers and the Chairmen of the elected committees for 1948-1949. The slate of officers is as follows:

<i>For President</i>	Joseph C. O'Connell
<i>Vice-President</i>	Edgar S. Potter
<i>President-Elect</i>	Peter Pineo Chase
<i>Secretary</i>	Morgan Cutts
<i>Treasurer</i>	Charles J. Ashworth
<i>Assistant Secretary</i>	Charles B. Ceppi
<i>Assistant Treasurer</i>	G. Raymond Fox

For the Standing Committees prescribed by the by-laws:

Committee on Scientific Work, Isaac Gerber

For Chairman of the Committee on Public Policy and Relations, Charles L. Farrell.

For Chairman of the Committee on Public Laws, William H. Foley.

For Chairman of the Committee on Post-Graduate Education, Marshall Fulton.

For Chairman of the Committee on Medical Economics, William P. Davis.

For Chairman of the Committee on Industrial Health, Stanley Sprague.

For Chairman of the Committee on Library, Herbert G. Partridge.

For Chairman of the Committee on Publications, John E. Donley.

That concludes the regular standing committees of the Society, Mr. President.

PRESIDENT RUGGLES: Thank you, Dr. Cutts.

It is now my great pleasure to present to you your new President, Dr. Joseph C. O'Connell. I am going to ask Dr. McLaughlin and Dr. Henry Moore to escort Dr. O'Connell to the platform. [Applause]

PRESIDENT O'CONNELL: Ladies and Gentlemen, I wish to take this opportunity to thank the members for my election to the Presidency of our Society. I really feel that it is a distinct honor. The office has been held by many distinguished members of our profession, not the least of whom is my predecessor in office. I do not expect to preside with the charm and the poise of Dr. Ruggles, but I shall do my best to keep the ship on an even keel, to be turned over next year to our President-Elect, Peter Pineo Chase.

The present committees for the coming year were made up, but they have not yet been published. I hope that the members will accept their appointments, and I am asking the Chairmen of the Committees to hold their meetings only when possible and then to notify the members sufficiently in advance so that they may be able to arrange their work to allow them to attend the meetings. I also suggest that they be supplied with a copy of the agenda of meetings, so that there may be a free discussion of the actions taken, so that it will be the action of the committee and not that of the Chairman.

I wish to thank Dr. Ruggles for the many courtesies shown to me during the past year. I also wish to ask the cooperation of the officers and the members of the society for the coming year.

Is there any business to be brought before the Society at this time?

If not, I will entertain a motion to adjourn.

Upon motion duly made and seconded, it was voted to adjourn.

PROVIDENCE MEDICAL ASSOCIATION

Next Meeting

MONDAY, OCTOBER 4



DR. J. C. O'CONNELL INDUCTED

Dr. Joseph C. O'Connell (left) new President of the Rhode Island Medical Society receives the official gavel from retiring President, Dr. Arthur H. Ruggles, while Dr. Peter Pineo Chase, President-Elect, views the proceedings.

HEALTH EDUCATION FELLOWSHIPS

The American Cancer Society has authorized the expenditure of \$10,000 for fellowships in health education. The present proposed plan is to offer eight fellowships of \$2,500 each (to be borne half by the Society and half by the state division) for graduate study in any one of the five approved schools of public health which include Yale University and the State Universities of California, Michigan, Minnesota and North Carolina.

The national office will name a Committee on Fellowship Awards who will make final selections from names submitted by state divisions. The applicant must have a B.S. or B.A. degree from an accredited school along with other specific requirements.

The eight selected students will obtain a nine months' study period and three months' supervised field training. Divisions may be permitted to contact the applicant for two to three years of service at the completion of the year's fellowship.

In addition to the above mentioned eight fellowships, several of the state divisions have already offered full fellowships within their own state budget.

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THE ANNUAL DINNER

137th Annual Meeting of the Rhode Island Medical Society

MAY 12, 1948

GUY W. WELLS, M.D., *Presiding*

Anniversary Dinner Chairman

DR. RUGGLES, Your Honor, Your Excellency, Guests, Ladies, and members of the Rhode Island Medical Society.

During the past few years the medical profession, as represented by the Rhode Island Medical Society, has been very deeply concerned about the provision of adequate medical care for the low income groups and has conducted within the Society many very detailed studies. We are gratified to know that our Chief Executive, Governor John O. Pastore, has also been keenly interested in the welfare and the health of our people, and

this movement, and has recommended and sponsored legislation appropriating funds to pay for the hospital care of such citizens. It is because of this alert and sincere cooperation of our Governor that it has been a pleasure to have him as our guest. It is unfortunate for us that Governor Pastore could not attend this dinner; he has, however, very kindly sent his representative, Lieutenant-Governor John S. McKiernan.

It is with pleasure that I shall now call upon His Excellency, Lieutenant Governor John S. McKiernan.

HONORABLE JOHN S. MCKIERNAN

LIEUTENANT-GOVERNOR OF THE STATE OF RHODE ISLAND

DR. WELLS, Dr. Ruggles, and other officers and members of the Rhode Island Medical Society and members of the Ladies Auxiliary, Guests, Ladies and Gentlemen.

In the absence of your good Governor, John O. Pastore, I deem it a great honor and a privilege to bring to your wonderful organization as it meets here attending its 137th Annual Dinner, the greetings on behalf of over 700,000 people. We know that you gather here yearly to renew acquaintances and also to exchange ideas and papers from which you, as individuals, receive the direct benefit, and from which the citizens as a whole receive the indirect benefit.

The Governor and the people of Rhode Island are proud of the way the members of your organization have contributed to the public welfare and the health of our great state. You have been directly responsible for great movements, like the clearing of the pollution problem, the purifica-

tion of air, the encouragement of and modernization of pasteurization of milk, and also alleviating and improving the industrial working conditions of our laborers. We are proud of these contributions, and I know I speak on behalf of over 700,000 people when I say that they are also proud of these contributions made by your Society to our citizenship here in Rhode Island.

We of the present administration are always willing to cooperate in any way we can with your organization. We know that you have the finest and the highest standards in your profession, and that you bring to your Association men of high moral and intellectual balance.

In the absence of your good Governor, I want to congratulate each and every one of you on your 137th Annual Dinner, and to wish you all good health, and may you all continue to make the same fine achievements and improvements to our public life in the future as you have done in the past.

THE DR. CHARLES V. CHAPIN AWARD

AS YOU KNOW, the Providence Medical Association, composed of members of this Society, is celebrating its 100th Anniversary, and all of us

are proud of one hundred years of continued service of the Association, both to the medical profession and to the public.

continued on page 446



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The long weeks of the hay fever season call for antihistaminic relief which is safe enough to be given over a protracted period.

For both effectiveness and tolerance, Hydryllin is indicated in hay fever, asthma, allergic rhinitis, urticaria, drug allergies, atopic and eczematous dermatitis.

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*Levin, S. J., and Moss, S. S.: Clinical Results with Hydryllin in Asthma and Hay Fever, to be published.

CHARLES V. CHAPIN AWARD

continued from page 444

The minutes of the first meeting reported a Committee of two members waiting on the Mayor to advise him on health matters for the city. I shall not go into the subject, but it was interesting. I think it was one hundred years ago this month that that occurred.

Particularly for the benefit of the out-of-town guests, I should like to say that the Rhode Island Medical Society and the Providence Medical Association are still meeting with the Mayor, and we are enjoying a very fine relationship with the city government. In recent years, we have conferred with Mayor Roberts, and we have not only been welcome, but have received his fullest cooperation.

I recall the early efforts of initiating action in such problems as air pollution, when the Mayor led a campaign which resulted in a city ordinance, and the Division of Smoke Control in the City Engineer's Department. And again, we stimulated interest in the better sanitation of eating places, and Mayor Roberts used his influence to carry through our recommendations. The City Council was most responsive.

I mention these examples briefly, merely to remind you that our efforts were for better community health and continued to meet with strong and willing support from the several leaders of Providence and Mayor Roberts may properly be recognized for his sincere and cooperative interest in health improvements.

As you know, it was as Director of Public Health in Providence that Dr. Chapin made his contributions that have influenced public health throughout the world. The City Council, in recognition of this work, have created an award to be given yearly to the Chapin Orator addressing the Rhode Island Medical Society at the Annual Meeting. This afternoon we listened to a splendid address on the subject of "Industrial Health" by Dr. Philip Drinker, Professor of Industrial Hygiene of Harvard School of Public Health. Dr. Drinker is the author and co-author of text books on "Industrial Health"; he is co-inventor of the Iron Lung, which has done so much for the victims of poliomyelitis. He has done more than any one else in the ventilation of submarines, and he has been the recipient of many honorary degrees; he has been awarded the John Towne Medal of the City of Philadelphia. He is a member of the American Public Health Association, American Chemical Society, American Heating and Ventilating Engineers, and the American Association of Industrial Health.

He is the only non-medical man who has been the recipient of this Award.

I am happy to present to you now Mayor Dennis J. Roberts, who will present the greetings of the City of Providence, and I am going to ask him, on this occasion, to make the presentation of the Chapin Medal to Dr. Philip Drinker.

HONORABLE DENNIS J. ROBERTS**Mayor of the City of Providence**

DR. WELLS, Distinguished Guests, Dr. Drinker, to whom we are to make the Charles V. Chapin Medal Award, Ladies and Gentlemen.

I am very happy to present, on behalf of the City of Providence and the Rhode Island Medical Society, the Charles V. Chapin Medal Award to this distinguished Doctor, Dr. Philip Drinker, who has contributed so much to the welfare of the United States, because of his very profound and intensive research in industrial hygiene, which we all realize is of tremendous importance to every community within our country.

I know that the doctors assembled here, and their friends, are very much aware of his contributions to the health of our country and to the health of our industrial communities.

I think that we are all grateful to him because of his contribution in the development of the iron

lung. I think that we all realize thoroughly what that has meant to many an unfortunate person who has been afflicted with infantile paralysis.

Perhaps that is not his greatest contribution to science, but it is one that is outstanding, and one that touches us all.

I want to assure the doctor that the people of Providence and those of the medical profession have a great deal of admiration and respect for his application of his very adequate talents, his profound intellect in behalf of the people of the United States, and his intensive research and development of procedures that have been given in the form of advanced industrial hygiene providing the people an opportunity to enjoy a better health standard.

It is my pleasure, Dr. Drinker, on behalf of the Rhode Island Medical Society, and on behalf of

continued on page 448

immediate symptomatic relief of ocular allergies



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MAYOR DENNIS J. ROBERTS

continued from page 446

the people of the city of Providence, to present to you the Charles V. Chapin Memorial Award. It is an award in honor of one of the most distinguished men of the medical profession of the State of Rhode Island. We are very proud of his reputation and of his contribution, and we are very proud of the distinction he has brought to this little city of ours, and to have you receive

this Award means to the people of Providence that you stand with him as one of the distinguished benefactors of public health in the United States of America.

I present this Award to you, Doctor, on behalf of the 253,000 people of the City of Providence, and your distinguished colleagues.

PRESENTATION OF GAVEL TO DR. A. H. RUGGLES

TOASTMASTER WELLS: It is our custom to present to the retiring President of this Society a symbol of appreciation of the Society for the future. I presume other societies have a similar tradition. Dr. Ruggles must be very familiar with this ritual, for I find that he has been President of both the County and the State Medical Societies of Providence and Rhode Island, and President of the New England Society of Psychiatry, President of the National Committee on Mental Hygiene, President of the Society of Neurology and Psychiatry, Secretary-Treasurer and President of the American Psychiatric Association, one of the six delegates to the International Congress for Mental Hygiene in Paris in 1937. Here, we know Dr. Ruggles as Director of the splendid institution, Butler Hospital, a hospital that has contributed so much to the study of psychiatric problems

and is now under his administration carrying out such a fine research program.

Dr. Ruggles, the Rhode Island Medical Society is deeply appreciative and grateful to you.

DR. RUGGLES: Dr. Wells, and members of this Society. I appreciate very much this tribute of the year's service. It has been a year of problems, complexities, of difficulties, and sometimes of frustrations; yet, it has been a splendid challenge of cooperative work, not only among the Committees of the Medical Society, but with the splendid help of the Women's Auxiliary, I feel that we have made progress and we have made it together. We must stand together in these difficult and complex days for the advancement that the President of the American Medical Association has so clearly put before us for the benefit of all of the people, through the medical profession.

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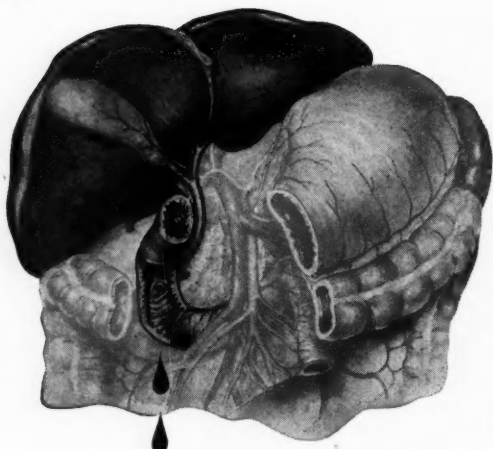
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¹ Friedlaender, A. S. and Friedlaender, S., *Amer. J. Med. Sc.*, in press.



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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NEUROLOGICAL ASPECTS OF POLIOMYELITIS

concluded from page 429

poliomyelitis is to be kept at five percent or less. Such a rate can only be maintained, when an epidemic with a high proportion of bulbar cases strikes a community, by cooperation of the public health officials, physicians, hospitals, ambulance services and nurses. Plans should be made long in advance so that special teams and adequate facilities will be ready. In recent years poliomyelitis has suddenly swamped hospitals in New Haven, Connecticut, Denver, Colorado, Minneapolis, Minnesota and smaller communities such as Hickory, North Carolina. On this point alone, it would seem advisable for every community to have a poliomyelitis commission whose chief duty would be to outline plans for the care of patients in an epidemic in their community. This can be done through the aid of the National Foundation for Infantile Paralysis but it is primarily a public health, hospital and physician's responsibility and they are the ones who should learn the lesson from the experience of a community such as occurred in Minneapolis in 1946. Every general hospital must open its doors to poliomyelitis if good results are to be expected in the future. The rest lies with you.

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- 2 Piszczek, E. A.: Treatment of Bulbar Poliomyelitis, Amer. Practitioner. 2:16-18 (Sept.) 1947.
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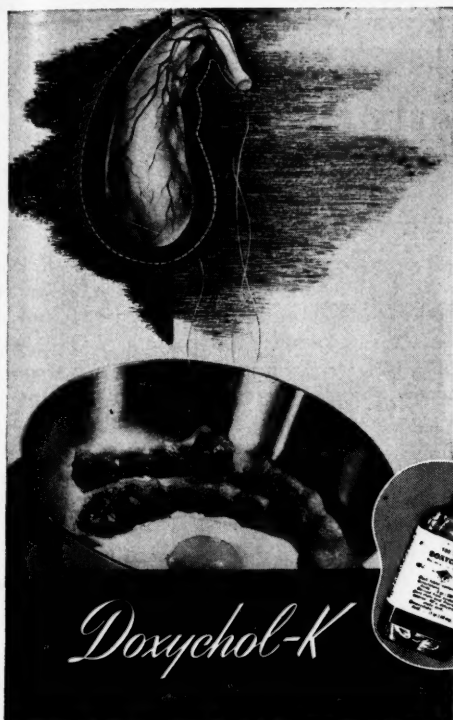
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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, May 25, 1948, with sixteen members attending.

The meeting was called to order at 9:05 p. m. by Dr. Henry Brownell, Vice President. At 9:30 p. m., Dr. Philomen P. Ciarla, President, took over. There was no old business.

Numerous communications were read.

Dr. Samuel Adelson moved that although the Society is in agreement with the content of the communication of May 4, 1948, from the Rhode Island Medical Society, a definite written agreement should be made with each Insurance Company and that this Society should be given a list of those companies that agree to the increased fee. Dr. MacLeod seconded. It was approved.

Dr. Adelson suggested that a Chairman be appointed to investigate the Newport Hospital's Laboratory fees to outside private patients and also suggested a communication be sent to Dr. Edward A. McLaughlin, State Director of Health, expressing regret that the State Health Department has had to discontinue blood chemistry examinations.

New Business: A committee of Drs. George Eckert, chairman, Samuel Adelson, Norman MacLeod and Charles Dotterer was appointed to work with the Rhode Island Medical Society for arranging a possible site here for the next annual Meeting of the State Society.

Dr. Norman MacLeod stated that the Board of Health plans to eliminate tuberculosis in the County and asked the cooperation of the Doctors to report cases of tuberculosis early and to support the drive that is planned.

Dr. Brownell moved that a lot of fifty official A.M.A. M.D. emblems with the name of the Society attached be purchased by the Treasurer and sold to members at cost. Dr. Adelson seconded. Motion approved.

Dr. Norbert Zielinski, treasurer, reported that as of May 25, 1948, the Society had \$308.00 in cash, \$392.00 due the Society and no outstanding bills.

Dr. Samuel Adelson moved that the President, Secretary, and Treasurer be a committee with

power to make concessions for members with long unpaid dues where any hardships might be involved. Dr. MacLeod seconded. Motion passed.

Dr. Charles Dotterer made a motion which was seconded by Dr. John Malone and passed that the Newport County Society adopt the payment of dues procedure of the Rhode Island Medical Society that "any member with respect to whom dues for that year have not been received by the Treasurer by October 1, after sixty days notice by the Treasurer, shall be suspended from membership in this Society."

The meeting adjourned at 10:20 p. m. Collation was served.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara, May 20, 1948, at 6:30 p. m. in the Nurses' Auditorium of the Memorial Hospital.

The minutes of the previous meeting were read by the Secretary and accepted.

A communication from John E. Farrell, Executive Secretary of the Rhode Island Medical Society was read. This called attention to the recommendation adopted by the House of Delegates relative to the increased fee rate for insurance examinations.

Another communication from the Washington County Medical Society deploring the recent discontinuation of blood chemistry examinations by the Rhode Island Division of Laboratories was read. Dr. Edward Foster presented a similar statement, signed by members of the Staff of the Memorial Hospital. Following some lengthy discussion, this matter was tabled.

The application for membership in the organization was read from Dr. Alice Madros Kechijian Bandeian. This was referred to the Standing Committee.

The application of Dr. Andrew Gerard Czekan-ski, having the approval of the Standing Committee, was submitted to ballot and unanimously accepted.

continued on page 454

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1. Frant, S., and Abrahamson, H.: *Brennemann's Practice of Pediatrics*, 1:28:22, 1945.

2. Blattner, R. J.: *J. Pediatrics*, 32:220, February, 1948.

CREMO

PAWTUCKET MEDICAL ASSOCIATION

continued from page 452

Dr. Charles L. Farrell gave a report of the recent meeting of the House of Delegates. The delegates from the Pawtucket Medical Society were instructed to reaffirm their stand in the recent controversy regarding the Dean's Committee for the Veterans' Hospital.

Dr. Charles Farrell, Program Chairman, introduced the Speaker of the evening, Dr. William McDonnell, Staff Anaesthetist, St. Joseph's Hospital, Providence. Dr. McDonnell's topic was "Responsibilities of the Anaesthetist." Following his paper, Dr. McDonnell gave an enlightening informal discussion on the problem of acute cardiac arrest and made a plea for standing orders and immediately accessible equipment to meet this emergency.

The meeting adjourned at 8:45 p. m. Twenty-two members attended.

Respectfully submitted,

KIERAN WILLIAM HENNESSEY, M.D.,

Secretary

FUNDAMENTALS OF STAFF ORGANIZATION

continued from page 438

chief of staff of the hospital and in many matters will go through him to the director. He must, however, have access to the director on certain matters. This again will vary considerably depending on whether he is full-time or not. The Chief of Service will assign ward work and the rotation of staff patients to the members of his staff. He will either be in charge of the Out-Patient Clinic or will delegate this authority to one of his subordinates. He will be responsible for the budget for his particular service and professional matters. In case the service concerned has residents training for a specialty, it will be his responsibility to see that their training program is adequate and that they are fairly treated by the administrative service of the hospital. I will go into this matter in considerable detail during the next hour. In case the hospital has other than private patients, he will be expected to make rounds on all staff patients at frequent intervals, and in some hospitals where only private patients are admitted, this is also expected. I know that this sounds strange to some of you, but I can point out hospitals in this country where only private patients are admitted and where the Chief of Service makes daily teaching rounds not only with the resident and intern staff, but also with students. If the calibre of the staff and the calibre of the Chief of Service and his associates is such that this is practicable, this will, I believe, lead toward better care for the individual patient.

If the hospital under consideration is not train-

ing specialists, but training men for general practice, then the rotation of the resident and intern becomes a responsibility of the Chief of Staff of the educational committee. This does not, however, absolve the Chief of Service from his responsibility of teaching the resident and intern staff.

It is also the responsibility of the Chief of Service to see that the records on his service are adequate, that certain medical legal problems are solved properly, such as the dispensing of narcotics, etc.

Role of Administration Staff

The administrative staff will be largely concerned with administrative matters and will in all probability relegate all professional authority to the attending staff through the Chief of Staff. There is one point, however, where they are directly concerned with patients, and that is in the building of good will towards their hospital. The reputation of an excellent institution is easily shattered by a snippy reception clerk, and all patients, regardless of their social and financial status, should be treated with the utmost courtesy and consideration during the time that routine admitting procedures are being carried out. It may seem unnecessary to stress this, but in a large institution all too frequently every patient feels that he is only a number and no one has any particular interest in his problem.

Certain procedures should be flexible enough to allow for the very ill patient to be admitted directly to a bed and the registration data obtained from a relative or at the bedside. This may be expensive, but not only will the hospital be building a reputation for courteous service, but the physician's job will be much easier. There are few doctors who cannot cite the experience of trying to calm a patient that has been riled up by the admitting staff before his medical workup can be instituted.

Consultation service within the hospital varies in different parts of the country. In some hospitals, with an open staff, any member of the staff may be called in consultation. In other hospitals, with closed staffs, certain members are designated as the consultant staff and only these may be used as consultants. This is one of the factors that can only be evaluated in light of local conditions and the recommendation as to its advisability could only be made if one had at hand all the factors concerned.

There are many types of staff organizations and most of them work to some extent. The most important thing about staff organization is that all members of the hospital staff, no matter what their duties may be, should have some insight into the general problems of the institution and a willingness to cooperate with all other members of the hospital so that the patient may be served more effectively.

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ANNUAL REPORTS

MAY, 1947 — MAY, 1948

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORT OF THE
TREASURER — 1947

During the past year the funds of the Society have been consolidated for more efficient administration of the financial affairs of the organization.

Notable building repairs have been completed, including the installation of modern lighting for the auditorium, the reading room, Miller room and stairways. In addition the reading room and stair halls were painted, and minor repairs made about the library building.

The general high cost of all commodities and services is reflected in our expenditures for the year, with increased outlays necessary for public utilities, printing, fuel, library and office supplies, books, the annual meeting, etc. In addition the Society has assumed added expense in connection with the voluntary prepaid surgical insurance program which has involved many conferences, the printing of literature, and legal services.

The Library building and its contents have been carefully checked by insurance experts and insurance to protect the investment of the Society has been purchased, involving increased premium charges

Within the year the tax status of the Society was reviewed by the Office of the Commissioner of Internal Revenue in Washington in the light of the decision in *American Medical Association v. Board of Review of Department of Labor* (Ill. 1946) with the result that we are no longer entitled to exemption under the provisions of section 101(6) of the Internal Revenue Code. This latter section provides for exemption for an organization *exclusively* educational, scientific, religious, or charitable. On advice of legal counsel we have not appealed this which makes us subject to social security taxes for employees, but not subject to income tax.

We completed the year with a cash balance in the general operating fund (total general fund less cash credited to the account of Special Endowment Funds) of \$7,027.86. This is hardly a sizeable surplus, especially when viewed in the light of cash reserves maintained by other state, and even county medical societies. For example, a district medical society in a neighboring state, in an area comparable to greater Providence, recently reported a cash reserve of more than \$38,000.

In the long range planning for the Society, as advocated by the special budget committee of the Council two years ago, recommendation was made that an effort be made yearly to allocate some of our surplus for a reserve or contingency fund. In keeping with that recommendation, therefore, I would suggest to the Council that \$3,000 of our present general fund be invested, possibly in government bonds, and set aside with the \$2,000 already owned in U. S. Treasury securities, as a contingency fund of the Society.

I direct the attention of the Society to the fact that other than the special Charles F. Gormly Fund created by the Council with the small surplus accruing from contributions from members to purchase the oil painting of Dr. Gormly in 1943, we have received no bequests since the Davenport Fund was established in 1930. It does seem as if some members of the profession, or friends of the profession, might be willing to establish while living, or otherwise as legacies, endowments to their own or others memories, whereby the education of physicians in general might be advanced, and the objectives of the medical profession and the Rhode Island Medical Society might be financially supported. I would recommend that the Council and the House of Delegates give this proposal very serious consideration, and that an official committee of the Society be considered to make a study with recommendations, or even to solicit funds for the endowment of our Society.

Financial Statement, 1947

Receipts, 1947,	
(Exhibit A) \$33,073.18	
Expenses, 1947,	
(Exhibit B)—29,553.17	
Cash Operating Surplus,	
1947	\$3,520.01
General Fund, Cash on deposit, January 1, 1947.....	5,416.42
General Fund, Cash on Deposit, January 1, 1948.....	\$8,936.43
* * * *	
General Fund, January 1, 1948.....	\$8,936.43

continued on page 458



QUESTION:

When is it good practice to suggest "Change to Philip Morris Cigarettes"?

ANSWER:

When patients under treatment for throat conditions persist in smoking, many eminent nose and throat specialists suggest "Change to Philip Morris"* ... the only cigarette proved** less irritating.

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**Reprints of published papers on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

ANNUAL REPORTS

continued from page 456

Less Cash credited to
the account of Special
Funds (Exhibit
C) -1,908.57

General Operating
Fund, January 1,
1948 \$7,027.86

* * * *

Invested Funds (General Account),
U. S. Treasury Securities \$2,000.00

Total Cash Assets (General Fund)
January 1, 1948 \$10,936.43

Exhibit A

Receipts, 1947

Annual dinner payments \$ 1,296.00
Council, payment by members for din-
ners at meetings 201.00
Dividends from investments 637.30
Donations 71.55
Dues from members 25,746.45
Ely Fund, 52 shares of R. I. Public
Service stock recalled 858.00
Exhibits, balance for 1947 meeting 1,046.00

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Exhibits, deposits for 1948 meeting 1,057.50
Miscellaneous 11.30
Providence Medical Association 2,148.08

TOTAL **\$33,073.18**

Exhibit B

Expenses, 1947

Annual Meeting (including dinner
payments) \$ 2,639.64
Books 210.59
Committees 375.51
Delegates to A M A House of Dele-
gates meetings 218.00
Donations and Dues 180.00
Electricity 55.33
Essay Contest (Cash Prizes) 175.00
Fuel 1,138.85
Gas 42.50
Insurance (Fire, liability, property
damage, annuity) 1,085.20
Legal 984.72
Library (miscellaneous) 132.53
Mid-winter meeting 83.49
Miscellaneous (Society and executive
office) 490.70
Office supplies and equipment 512.68
Postage 337.14
Printing 535.44
Repairs to Library (including new
lights, painting, etc.) 3,840.69
Salaries 16,079.90
Social Security Taxes 192.00
Telephone 220.14
Woman's Auxiliary 23.22

TOTAL **\$29,553.17**

Exhibit C

SPECIAL FUNDS

J. W. C. ELY FUND

A memorial fund established in 1912 by the son
and the granddaughter of Dr. J. W. C. Ely, in the
amount of \$1500, to be called the J. W. C. Ely
Fund and the income from which was to be used
for periodicals.

Investments

52 shares, New England Electric
Company \$ 624.00

Cash in General Fund of Society

R. I. Public Service Co.
stock recalled, 1947 \$ 858.00
Cash balance from unused
dividends, 1946 40.65
Stock dividends, 1947 78.00

\$ 976.65

ANNUAL REPORTS

459

Periodicals purchased, 1947	—128.50
Cash balance in General Fund, January 1, 1948	\$ 848.15

* * * *

Endowment Fund

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2/12 of the annual income, amounting that year to \$69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

Investments

16 shares, National Bank of Commerce	\$1,200.00
74 shares, Providence Gas Company	906.50

Dividends, 1947, (Used for Library Building repairs)	\$ 88.70
--	----------

E. M. HARRIS FUND

Established in 1921 by a donation of \$5,000 by Dr. E. M. Harris for "upkeep of the Library Building".

Investments

25 shares, Consolidated Edison Elec- tric Company	\$2,346.88
64 shares, Nicholson File Company	2,719.00

Dividends, 1947, (Used for upkeep of Library building) Consolidated Edison Electric Company	\$ 125.00
Nicholson File Company	170.20
	\$ 295.20

* * * *

HERBERT TERRY FUND

Established in 1928 by a donation of \$2,000 from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

Investment

96 shares, Providence Gas Company	\$1,152.00
<i>Cash in General Funds of Society</i>	
Cash balance from unused dividends, 1946	\$ 19.40
Dividends, 1947	52.80
	\$ 72.20

Books and periodicals pur- chased, 1947	—63.00
--	--------

Cash balance in general funds, January 1, 1948	\$ 9.20
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* * * *

JAMES R. MORGAN FUND

Established by a donation of \$500 in 1929 to be used for current expenses.

Investment

43 shares, Providence Gas Company	\$ 526.75
---	-----------

Dividends, 1947, (Used for current expenses)	\$ 23.65
---	----------

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of \$1,000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

Investment

89 shares, Providence Gas Company	\$1,068.00
---	------------

Cash in General Fund

Cash balance, January 1, 1947	\$ 949.09
Dividends, 1947	48.95

\$ 998.04

*continued on next page***JAMESTOWN, RHODE ISLAND**

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ANNUAL REPORTS

continued from preceding page

Books purchased, 1947.....	—15.04
Cash balance in General Fund, January 1, 1948	\$ 983.00

THE CHARLES F. GORMLY FUND

Established by the Society in 1945 with a cash balance of \$102.51 accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Society in 1943. The Fund was established for the purchase of medico-legal books to form the Charles F. Gormly collection.

Cash balance in General Funds, January 1, 1947.....	\$ 72.27
Books purchased, 1947	4.05

Cash balance in General Fund, January 1, 1948	\$ 68.22
--	----------

* * * *

FRANK L. DAY FUND

Established is 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

Investment

3,000 shares, Canadian National Railway Company	\$2,979.75
Cash, Industrial Trust Company, checking account	

Balance, January 1, 1947	\$ 784.59
Dividends, 1947	135.00

	\$ 919.59
Books purchased, 1947.....	227.90

Balance, January 1, 1948.....	\$ 691.69
-------------------------------	-----------

CHARLES J. ASHWORTH, M.D.,

Treasurer

THE FISKE FUND

This is the 113th year of the Fiske Fund. The Trustees of this Fund are Dr. Arthur Ruggles, Dr. Joseph C. O'Connell and Dr. Isaac Gerber.

On November 13, 1947, the first meeting of the year was held at the home of Dr. Gerber and it was attended by Drs. O'Connell, Gerber and Pickles. Dr. Pickles presented an account of the low income of the fund, due to the changed interest rates and the methods of investment required by the court order. There were presented copies of correspondence with Mr. Wells of the trust company and their counsel, suggesting measures that might be taken to gain relief from the existing

situation. The Trustees decided to ask the council of the Rhode Island Medical Society to assume the court proceedings, aimed at allowing investment of the funds in government bonds, where a return of 2½ per cent might be expected. This action was decided upon.

The Secretary reported the financial standing of the fund to be as follows: I shall not read it in detail. But, the fund at the moment amounts to \$12,954.21.

A meeting, which was the second meeting, was held on March 18, 1948, also at Dr. Gerber's home, and this meeting was attended by Drs. Ruggles, O'Connell, Gerber and Pickles.

Dr. Gerber reported that the council of the Rhode Island Medical Society approved the proposed action of the Trustees in seeking a revision of the investment of the funds, and it was agreed to defray the cost of legal action.

During the subsequent discussion, it was brought out that the legal firm of Tillinghast, Collins and Tarrant had made a complete study of the matter for the Rhode Island Hospital Trust Company, and had already done much of the ground work.

On motion of Dr. Gerber, the secretary was directed to take legal action to bring about the desired change.

There being no further business, the meeting was adjourned.

I now present an interim report for this annual meeting. The Secretary is pleased to report that Colin Makepeace of the legal firm mentioned above has undertaken to present a petition to the Supreme Court, requesting authority to change the method of investments. It is felt that as a result of this the fund will be able to resume its normal activities during the coming year.

This report is respectfully submitted by the Secretary.

WILFRED PICKLES, M.D.

COMMITTEE ON CANCER

Cancer Control work in Rhode Island has gone on in the last year without any great change in its organization. The cancer division of the State Health Department has established cancer detection clinics at the Memorial, Newport and Rhode Island Hospitals. These clinics have been functioning now for over a year and should be able to produce some statistical reports soon, which should show their value. In addition to this, the statistical work in the department has been going on and material accumulating.

The Rhode Island Cancer Society, affiliated with the American Cancer Society, has gone forward with its program of lay publicity, and of raising of

continued on next page

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funds for cancer research for care of the indigent cancer patient, for transportation of patients to clinics, and has about completed a home for convalescent or terminal patients.

Your Chairman has been in consultation with Dr. McLaughlin and Dr. Pitts of the State Health Department and Cancer Society respectively, on several occasions in the past year. It has been apparent for some time that cancer control in Rhode Island suffers from the lack of a full time executive. The burden of carrying out details of a full-fledged cancer program is just too much for any man not on full time. This has been recognized by all of us, but it has not been until this last month that such a man has become available. We are glad to announce that Dr. Walter Batchelder has been found acceptable by Dr. McLaughlin, to head up the Division of Cancer Control of the State Health Department and will report about the first of August.

This is an important milestone in the progress of all of the three agencies concerned, — the State Health Department, the Rhode Island Cancer Society and the State Medical Society. It is felt by your committee that the time is now ripe for the Medical Society to act together with these other agencies, our part being the raising of greater interest in the cancer problem among doctors of the community. We believe that the ultimate responsibility for discovery of early cancer lies with the family doctor. Detection clinics can only set the pattern for types of examination required, and while being of great educational value to doctors as well as patients, can never cover the field of discovering cancer in its early treatable stages among all of the people in any community.

Your committee therefore proposed that a meeting be held next Fall, the date being set for a Wednesday in November. The purpose of this meeting is to arouse interest in cancer by having speakers covering the fields, of research, early diagnosis and treatment and by exhibitions to be pro-

RHODE ISLAND MEDICAL JOURNAL

cured from the different hospitals of the State and from the resources of the Cancer Society.

At a meeting of the committee held April 22, 1948, it was voted to approve in principle such a meeting, details to be worked out immediately. Your committee also would like to recommend that each County Society have a cancer committee made up of three members, the chairman of each of these committees to be a member of the State Cancer Committee. Meetings of the State Cancer Committee would then be held in each of the counties from time to time. It is also suggested that the State Committee send out pamphlets or articles concerning cancer from time to time, to all members of the State Society.

In conclusion, it is our hope that with a full time man in the State Health Department and with the cooperation of the Rhode Island Cancer Society and the Cancer Committee of our Society, that a cancer control program, equal to that found in any state of the Union may be evolved.

George W. Waterman, M.D., *Chairman*
Joseph O'Connell, M.D.
Linwood H. Johnson, M.D.
Henry B. Moor, M.D.
William Fain, M.D.
G. Raymond Fox, M.D.
Philip Batchelder, M.D.
James M. McCarthy, M.D.
James C. Callahan, M.D.
E. Victor Conrad, M.D.
Herman C. Pitts, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

The activities during the past year of the Committee on Industrial Health consisted of:

(a) A meeting of the Committee with the Director of the Workmen's Compensation Division.

(b) A meeting with the agents representing Workmen's Compensation insurance companies of this state.

(c) A hearing before the Workmen's Compensation Law Commission.

(d) Submission of the report by the Committee adopted in general by the House of Delegates.

(e) Amendments ordered by the House of Delegates submitted to the Workmen's Compensation Law Commission.

(f) Attendance and report, A A M Industrial Health meeting at Cleveland, January, 1948.

(g) Attendance at the National Convention, American Association of Industrial Physicians and Surgeons at Boston, March and April, 1948.

(h) Two personal meetings with Dr. Carl Peterson, Chairman of the Industrial Health Council of the American Medical Association, with requests as to further activities in the state of Rhode Island along industrial health lines.



The Alkalol Company, Taunton 12, Mass.

(i) At present arranging with the Connecticut Medical Society's Industrial Health Committee for a meeting in Hartford May 27, 1948.

Stanley Sprague, M.D., *Chairman*
James P. Deery, M.D.
Arthur E. Martin, M.D.
George Conde, M.D.
Richard F. McCoart, M.D.
Robert L. Bestoso, M.D.
Edward Medoff, M.D.
Charles L. Farrell, M.D.
Thomas A. Egan, M.D.
Francis E. Hanley, M.D.

COMMITTEE ON THE LIBRARY

The Library has been most fortunate in the number of gifts it has received during the past year. Doctor Arthur H. Ruggles presented us with a book cart, thus answering a long-felt need for an easy way of moving heavy volumes. The Providence Journal Company selected our Library as one of those to which it is giving the CONGRESSIONAL QUARTERLY. Under the terms of the will of the late Anna Augusta Chapin, we received Doctor Chapin's medals, the cup presented to him on the 40th anniversary of his election as Superintendent of Health and a case of instruments given to him when he was House Physician at Bellevue Hospital in 1880.

We received books from Mrs. Jesse H. Metcalf, Doctors Russell S. Bray, William P. Buffum, Arthur E. Martin and Herbert G. Partridge, and from the Estates of Doctors Harlan P. Abbott and R. Morton Smith. Journals were given us by Doctors Irving A. Beck, Francis V. Corrigan, Frank T. Fulton, Roland Hammond, Louis I. Kramer, Helen C. Putnam, Frederic W. Ripley, and Stephen A. Welch. Gifts from libraries, hospitals, organizations, publishers, government agencies and pharmaceutical companies have added many titles to our collection.

We have made use of the facilities of the Medical Library Association Exchange for the first time and, through this clearing house for duplicates, we have been able to fill in some of the lacks in our journal runs. The Exchange enables members of the Medical Library Association to give duplicates and receive needed items with no expense other than the mailing costs of material received.

Two cartons of duplicate journals were sent to the Roscoe B. Jackson Memorial Laboratory in Bar Harbor, Maine to aid in the restoration of their library which was destroyed by fire.

The Library grows steadily. Two hundred and eighty-two books, many journals and pamphlets were added through gift, purchase and exchange. Of the books purchased, twenty-four were for the main library, eight for the Davenport Collection and one for the Gormly Collection. Two hundred and twenty-six periodicals (journals, transactions, reports, etc.) are received regularly. We have begun subscriptions to two journals — the AMERICAN JOURNAL OF MEDICINE and PSYCHOSOMATIC MEDICINE — and have renewed a former subscription to the SOUTHERN MEDICAL JOURNAL which had been allowed to lapse.

Fifty-eight journals have been converted by binding; fifty-two volumes are at the bindery now.

The volume of reference work has increased and is divided about equally between work done by the reader in the Library and telephoned requests wherein the material is called for and taken out by a member of the Society. We have had a total of 1,973 visitors; 281 of these came during evening hours. The circulation figures are: 911 journals and 224 books charged out and returned; 126 journals and 51 books out at present. These figures do not give a very clear picture of the number of volumes consulted, however, as by far the greatest number are used in the building.

We have borrowed 18 journals, 2 books and 7 pamphlets from other libraries through Interlibrary Loan. We have loaned 154 journals and 24 books.

The increase in the number of volumes during the past few years has made it necessary to move nearly every book and journal in the building. We have started this project and hope to finish reorganizing the first floor stacks this spring. 23,611 volumes have been catalogued to date.

Russell S. Bray, M.D., *Chairman*
Herbert G. Partridge, M.D.
Herbert E. Harris, M.D.
Robert T. Henry, M.D.
Paul Appleton, M.D.
Whitman Merrill, M.D.
Paul C. Cook, M.D.
Amy E. Russell, M.D.
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COMMITTEE ON MATERNAL HEALTH

The Committee for the study of Maternal Deaths of the State's Society submits the following report.

For the year 1947 there were 16 maternal deaths due to obstetrical causes in the State of Rhode Island. This number of deaths occurred in 18,498 cases. These figures were supplied by the State Board of Health to the Committee.

These deaths have not been investigated by the Obstetrician employed for this purpose by the Department of Health who in previous years has cooperated with the Committee in supplying this investigator.

We have the assurance of Dr. Francis V. Corrigan of the State Board of Health that more active investigation will be resumed this year.

John G. Walsh, M.D., *Chairman*
Michael H. Sullivan, M.D.
George E. Bowles, M.D.
Alfred L. Potter, M.D.
John F. Murphy, M.D.
Richard H. Dowling, M.D.

COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

This committee has been moderately active throughout the year and several cases have been submitted for discussion and recommendation. In one case, settlement was advised and in another case, where the charge was obviously unjust, the committee recommended that the suit be defended in Court. The verdict resulted in a non-suit and unless the decision is appealed to the Supreme Court, the result may be considered as a victory for the physician and the entire medical profession. The committee is never inactive and cases are constantly being brought to our attention. In some cases the matter is easily disposed of and it is only rarely that serious discussion is required of the

entire membership. At this time, the committee wishes to emphasize that physicians should report promptly any case where a patient seems likely by his attitude to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment even if the case has not been referred to a lawyer.

Roland Hammond, M.D., *Chairman*
Norman S. Garrison, M.D.
John E. Ruisi, M.D.
Fenwick G. Taggart, M.D.
James L. Wheaton, M.D.
Robert H. Whitmarsh, M.D.
John F. Kenney, M.D.

COMMITTEE ON TUBERCULOSIS

Your Committee has continued to work on the problems of tuberculosis control. A plan for tuberculosis control in the hospitals of Rhode Island was drawn up and sent to the various hospitals in the State. A copy of this was published in a previous issue of the Journal. A follow-up letter is to be sent annually to these hospitals with a form to be filled out, indicating what procedures are used and what results are obtained.

Because of the shortage of tuberculosis beds and the consequent long waiting lists for patients seeking treatment for tuberculosis, a sub-committee was formed to study conditions at Wallum Lake Sanatorium. It was the hope that they might be able to find some means by which more patients could be handled. After their visit to the Sanatorium, it was felt that everything within reason was being done, that the shortage of beds was a result of difficulty in hiring and keeping personnel at the Sanatorium. It appeared that the only means of immediate improvement would be to cut down the stay of the Sanatorium patients to the minimal period compatible with adequate care.

The Committee is of the opinion that to further promote interest and understanding of tuberculosis



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problems, it would be advisable for the various county medical societies to appoint tuberculosis committees for the purpose of studying and handling local problems.

The matter of tuberculosis control amongst school teachers has been discussed, and the Committee is of the opinion that it would be advisable to have chest plates of all teachers annually. Further, it would seem advisable to have annual x-rays of all school employees, especially those who come in close contact with pupils. A definite program for this procedure has not yet been worked out.

The Eastern Section of the American Trudeau Society has been inactive during the War years. The officers of the Section are interested in carrying out a program that will be helpful to the localities covered by this Section and has requested recommendations from the various states. In discussing this matter, the Committee felt that the Section would serve a more useful purpose if it were not so large, if there were a New England Section to represent this particular region, and that it might combine with other local groups interested in tuberculosis in order to prevent a certain amount of repetition and to provide a more unified program. It was suggested that the Eastern Section might draw up a list of speakers who could be called upon to give talks to local societies on various aspects of tuberculosis. These recommendations will be presented at the forthcoming meeting of the Eastern Section of the American Trudeau Society.

John C. Ham, M.D., *Chairman*
 Royal C. Hudson, M.D.
 Daniel A. Smith, M.D.
 Philip Batchelder, M.D.
 Lewis I. Kramer, M.D.
 Charles L. Southey, M.D.
 Peter F. Harrington, M.D.
 U. E. Zambarano, M.D.
 James P. Deery, M.D.

COMMITTEE ON WATER POLLUTION

This year the committee has no intensive work on their part to report. As you know the campaign started by us resulted successfully and the referendum for financing the installation of a sewer project in the Blackstone Valley was passed and governmental steps to get this under way have already been taken. Last summer a larger area of the bay was closed to bathing and the taking of shellfish. A state pollution abatement committee has been active and Drs. Chase and Farrell of our own committee have been members of that. Besides this, the General Assembly have authorized a number of communities to issue bonds for

continued on page 467

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170 Waterman St. Providence 6, R. I.

VINCENT J. RYAN, M.D.

*Practice limited to
Dermatology and Syphilology*

Hours by appointment Call GA 4313
198 Angell Street, Providence, R. I.

CARL D. SAWYER, M.D.

*Practice limited to
Dermatology and Syphilology*

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